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EVALUATION

Mid-term performance evaluation of the USAID-funded UNICEF Maternal and Child Health Integrated Malaria Control Program in Eastern Indonesia

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Content

A. ACRONYMS and ABREVIATIONS

ACT	Artemisinin-based Combination Therapy
ANC	Antenatal Care
ABER	Annual Blood Examination Rate
AKBID	Akademi Kebidanan: Midwifery Academy
APBD	Anggaran Pendapatan dan Belanja Daerah (District Revenue and Expenditure Budget)
API	Annual Parasites Incidence
ART	Antiretroviral Therapy
ATM	AIDS, Tuberculosis and Malaria Center
BAPPEDA	Badan Perencanan Pembangunan Daerah (Local Development Planning Board)
BEONC	Basic Emergency Obstetric and Neonatal Care
BPS	Badan Pusat Statistik (National Statics Office)
BOK	Biaya Operational Kesehatan, or Operational Health Funds
Bapelkes	Provincial Health Training Center
Bupati	Head of district
Cadre	Community volunteer
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CHC	Community Health Center (*Puskesmas)*
CEONC	Comprehensive Emergency Obstetric and Neonatal Care
DHO	District Health Office
DHS	Demographic and Health Survey
EMAS	Expanding Maternal and Neonatal Survival, a USAID program
EPI	Expanded Program on Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOI	Government of Indonesia
NGO	Non-governmental Organization
IBI	Ikatan Bidan Indonesia (Indonesian Midwives Association)
IDAI	Ikatan Dokter Anak Indonesia (Indonesian Pediatricians Association)
IMP	Integrated Microplanning
IPT	Intermitted Preventive Treatment
Jamkesmas	Jaminan Kesehatan Masyarakat (Community Health Insurance)
Jampersal	Jaminan Persalinan (Delivery Insurance)
JKN	Jaminan Kesehatan Nasional (Universal Health Coverage)
KIE	Knowledge, Information and Education
LLIN	Long-lasting insecticide treated bed net
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MIP	Malaria in Pregnancy
MNCH	Maternal, Neonatal and Child Health
MCH/IMC	Maternal and Child Health / Integrated Malaria Control
MMR	Maternal Mortality Rate
NMR	Neonatal Mortality Rate
MOH	Ministry of Health

MTB	Maluku Tenggara Barat District (district in eastern Indonesia)
MWH	Maternity Waiting Home
NMCP	National Malaria Control Program
NTB	Nusa Tenggara Barat, (West Nusa Tenggara, a province in Eastern Indonesia
NTT	Nusa Tenggara Timur (East Nusa Tenggara), a province in Eastern Indonesia
PERDA	Peraturan Daerah (District or province regulation)
PHO	Province Health Office
PKK	Pembinaan Kesejahteraan Keluarga (Family Welfare Movement)
PLA	Participatory Learning and Action
PMTCT	Prevention of Mother-to-Child Transmission
Polindes	Pondok Bersalin Desa (Village delivery post)
Poltekkes	Politeknik Kesehatan (Polytechnic health academy)
Posyandu	Pos Pelayanan Terpadu (Integrated Health Service Post)
Puskemas	Pusat Kesehatan Masyarakat (Community Health Center)
Pustu	Puskemas Pembantu (Sub-CHC)
RDT	Rapid Diagnostic Test
RSCM	Rumah Sakit Dr. Cipto Mangunkusumo
RSUD	Rumah Sakit Umum Daerah / District Hospital
SBA	Skilled Birth Attendant
SB	Sekolah Bidan: midwifery school
SOP	Standard Operating Procedure
TB	Tuberculosis
TBA	Traditional Birth Attendant
TWG	Technical Working Group
UNDIP	Diponegoro University
UNHAS	Hasanuddin University
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

B. Executive Summary

Introduction

Indonesia has a population of 238 million: the fourth largest population in the world and is the largest economy in South East Asia. Despite impressive macro economic growth figures, significant health challenges remain: over 40% of the population or around 105 million are living on less than 2 US$ a day and the progress on maternal health (MDG 5) has slowed down: maternal mortality rate (MMR) (number of deaths among pregnant women / within 42 days after delivery per 100,000) declined from 390 / 100,000 in 1991 to 228 / 100,000 in 2007 and was in 2012 pegged at 359 / 100,000. Infant and child mortality (MDG 4) is currently 32 respectively 40 per 1,000 live births. Especially the reduction of neonatal mortality rate (NMR) has stalled: still at the 2007 level: 19 deaths per 1,000 births.[1] This performance is, compared to other Asian socio-economic less developed countries, rather poor and Indonesia will probably not meet these MDG targets next years.[2]

East Indonesia is a high Malaria transmission area because it has ideal mosquito breeding grounds: dense tropic forests, swamps, marshes and shallow water basins. This part of Indonesia also has a myriad of remote islands in Maluku, an extremely difficult highland terrain in Papua, and is home to the 4 provinces with the highest percentage of relative poverty[3,4]. Malaria is important in endemic areas, like Eastern Indonesia and can be responsible for maternal deaths both during acute malarial episodes and afterward because of the effects of the disease on maternal anemia[5].

In East Indonesia the 3 leading causes of maternal mortality are: 1. Haemorrhage: 34% (including: post- and antenatal haemorrhage, placenta previa, and premature separation of placenta). This is higher compared to other Indonesian areas. 2. Eclampsia: 26% (including: edema, proteinuria, and hypertensive disorder). This is lower compared to other Indonesian areas. 3. Infection and puerperium problems, including Malaria (30%) (One of the highest compared to other Indonesian areas)[6]. Neonatal mortality also in Indonesia is typically attributed to one of three major causes: infection, asphyxia, or

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1 Indonesia - Demographic and Health Survey 20122013; Statistic Indonesia, National Population and Family Planning Board, Ministry of Health, Measure DHS, ICF International: Accessed from: http://dhsprogram.com/publications/publication-FR275-DHS-Final-Reports.cfm.

2 Issue Briefs: Maternal and Child Health [database on the Internet]. UNICEF Indonesia,. 2012 [cited August 7, 2014]. Accessed from: http://www.unicef.org/indonesia/A5-_E_Issue_Brief_Maternal_REV.pdf.

3 World Bank. Indonesia Economic Quarterly - Slower Growth; High Risks2013: Accessed from: http://www.worldbank.org/content/dam/Worldbank/document/EAP/Indonesia/IEQ-Dec13-ENGLISH.pdf.

4 North Maluku, Maluku, West Nusa Tenggara, East Nusta Tenggara, West Papua and Papua - Poverty - Percentage of Poor People, Rural [database on the Internet]. knoema.com. [cited September 8, 2014]. Accessed from: http://knoema.com/atlas/embed/Indonesia/North-Maluku/topics/Living-Conditions/Poverty/percent-of-Poor-People-Rural?compareTo=ID-MA,ID-PB.

5 Ibid.

6 Joint Committee on Reducing Maternal and Neonatal Mortality in Indonesia. Reducing Maternal and Neonatal Mortality in Indonesia : Saving Lives, Saving the Future. 2013.

prematurity. Indonesia relies on national IDHS data. The IDHS National NMR: 20/1000, which is about 50% of the Infant Mortality rate (which was according to IDHS 2012 45/1000 live births). According to IDHS 2012 NMR per province: Papua: 27, West Papua 35, NTT 26, Maluku 24, North Maluku 27/1000 live births.[1] Most if not all of these maternal and neonatal deaths are preventable. About 50% of maternal deaths are managed by a health professional before death[7] while in Malaria endemic situations up to 25% of the maternal deaths can be attributed to Malaria.[8]

Socio-economic, educational, cultural factors and the poor access to services, due to the extreme geographical settings, are problems beyond short time interventions. In addition delays in recognition of a maternal/neonatal emergency, decision making and transport/referral, and the quality of services: the classic "three delays and lack of quality of services" can be targeted as we can learn from other countries who managed to reduce both maternal and neonatal mortality to the MDG targets in a rather short period of time span (5-10) years. The MCH/MIP program approach of using Malaria prevention, diagnoses and treatment as a vehicle to strengthen the complex system- prevention- and care interventions is an innovative approach that will lead to professional synergy[9] and is planned to reduce malaria in pregnancy and maternal and neonatal death[3].

The current USAID-funded and GoI/UNICEF implemented Maternal Child Health and Integrated Malaria Control in Eastern Indonesia project (MCH/MIP) covers past years activities from two separate projects: Malaria in Pregnancy (MIP) and the ACHIEVE: the former MNCH project. This integrated project started on October 1, 2010, will expire on September 29, 2015, and is funded through a five-year grant, which is as MCH Umbrella Grant awarded to UNICEF/NY Health Section for health and immunization response support. The program is in sync with both USAID and UNICEF's overall goal to support GoI in attaining the MDG 4, 5 and 6, and is designed to implement activities to improve MCH through utilizing evidence-based activities and practices, to improve the continuum of care as it links to communities, primary level facilities, and hospitals in Eastern Indonesia[10].

The purpose of the mid-term evaluation was to assess UNICEF's progress towards their stated objectives and indicators in this project, and to make specific recommendations to improve the project's performance and future programming.

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7 Ronsmans C, Scott S, Qomariyah SN, Achadi E, Braunholtz D, Marshall T, et al. Professional assistance during birth and maternal mortality in two Indonesian districts. Bull World Health Organ. 2009 Jun;87(6):416-23.

8 Steketee RW, Nahlen BL, Parise ME, Menendez C. The burden of malaria in pregnancy in malaria-endemic areas. Am J Trop Med Hyg. 2001 Jan-Feb;64(1-2 Suppl):28-35.

9 WHO Bulletin. Editorial. 2005 April;83(4).

10 Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia revised 3-08-2013. USAID project document regarding incremental funding to immunization in collaboration with CDC. Jakarta2013.

Methodology

The evaluators used a mixed quantitative-qualitative design. For the quantitative analysis the evaluation team compared numerical aggregated provincial data from the year 2013 on MCH/MIP program progress on targets/indicators, against 2010 Baseline MCH/MIP program targets/indicators data. The team performed an overall progress on program targets/indicators and an analysis of progress on MCH/MIP program targets/indicators per province. For the qualitative analysis the evaluation team performed a desk study of available MCH/MIP program documentation and conducted structural interviews and focus group discussions with informants. For this purpose a structural overall interview guideline was developed of which subsequently 5 specific interview guidelines were derived for interviewing stakeholders form MoH national, UNICEF Country Office, DHO/PHO, UNICEF Provincial Offices and for focus group discussion with clients. A result matrix was developed containing detailed questions on: progress towards the project's objectives, target, focus and scalability of the project to support GoI investments in MCH/MIP, appropriateness, accuracy and specificity of indicators, donor coordination and harmonization and the integration of the two formerly-separate MIP and ACHIEVE projects. The informants were: national and local level government staff working at both policy and technical levels, USAID, UNICEF and CDC professional staff, a representative from Global Fund for Aids Tuberculosis and Malaria (GFATM), representatives from two other USAID funded programs related to mother and neonatal health care: Kinerja and EMAS, UNICEF MCH/MIP program staff and clients/patients in 3 of the 5 Eastern Indonesian provinces: Maluku, Papua, West Papua. Due to time limits the evaluation team, together with USAID/UNCEF Country offices, selected the above-mentioned provinces. The quantitative analysis covered all 5 provinces of Eastern Indonesia: Maluku, North Maluku, Papua, West Papua and Nusa Tenggara Timor (NTT). The qualitative analysis covered the above-mentioned 3 provinces. The evaluation lasted from August 18-28,2014.

Findings

Comparing the MCH/MIP program baseline targets/indicators from 2010 against the 2013 performance indicators, it was concluded that over all provinces and over all indicators 46% reached 100% or beyond the targets/indicators and 78% of the targets/indicators were reached at 50% or beyond. Most targets seemed to be set realistic and program progress was good. Some specific selected findings are listed below:

1. Improvement of district health system (objective 1 of the MCH/MIP program) was measured by the number of Health Centers reporting no stock outs of essential items for the integrated Malaria program supplies: artemisinin-based combination therapy (ACT), rapid diagnostic test (RDT) and long-lasting insecticide treated bed nets (LLIN) or maternal

health program: magnesium sulphate, oxytocin, intravenous antibiotics (MCH/MIP indicators 5-10). It proved that no data at all were collected for MCH indicators (8, 9, 10), while for the Malaria indicators, NTT province did not report and Maluku province reached 86% on the stock of LLIN distribution (indicator 7) while all other provinces (Maluku Utara, Papua, West Papua and NTT reached 100% or more on indicators covering the stocks of LLIN, ACT and RDT (ind.5, 6, 7).

2. To measure service quality the proportion of pregnant women attending first ANC contact who receive screening and appropriate treatment (indicator 12 & 13) were recorded: Maluku Utara reached on both the Malaria and MCH target 84%. West Papua reached only 30% of its Malaria target while Papua did not report at all on the MCH indicator (13). Maluku and NTT Province reached respectively 52% and 72% on both the Malaria and MCH indicators. Papua reached 58% on Malaria Indicator (12) and West Papua 57% on the MCH Indicator.
3. In order to measure increase of coverage of the integrated MCH/MIP program through advocacy and leveraging of local Government/GFATM funds (Malaria Objective 3) the number of districts with budget allocation for integrated MCH /MIP program that is at least equal to the total contribution of the GFATM and UNICEF, was recorded (Indicator 18). Analysis of the routine reported data revealed that only Maluku Utara and Papua reached 100% or more on the targets of this indicator. Maluku and West Papua showed no progress and NTT did not report on this indicator.
4. East Indonesia combines a very poor referral system, due to extreme geophysical setting with a low professional density: of the 1700 OB&GY's, 14 work in Papua and only 9 in Maluku. Also neonatology and anesthesiology are underdeveloped in this part of Indonesia.
5. In order to ensure that all women and newborns receive comprehensive and quality care during pregnancy, delivery and postnatal periods the proportion of delivery assisted by skilled birth attendance was recorded. The results showed that Maluku Utara and Maluku reached respectively 75% and 53% of their targets, while Papua, West Papua and NTT reached over 100% of their targets.

Recommendations

1. To counter the regular Malaria and MCH stock-outs it is recommended that UNICEF advocates for a buffer stock at DHO-PHO level for Oxytocin, Magnesium sulphate, RDT and ACT and ILLNs, and increases its efforts to strengthening the referral system and the quality of BEONC sites whereby action is required from UNICEF and the District and Provincial Health offices (DHO/PHO).
2. The successes of the ILLN, Malaria screening and treatment, in terms of increased first ANC visit and increased immunization figures, probably does not contribute much to

increase the proportion of deliveries assisted by skilled midwives. Beside the development of buffer stocks it is recommended to use the synergy obtained by the integrated program to inform expecting mothers of the benefits of the JKN health insurance scheme, and to promote skilled delivery at an official BEONC site whereby action is required from UNICEF and DHO/PHO level.

3. The integrated MCH/MIP program has proven to be successful in leverage of other funds like APBD (Local Government) funds in Maluku and North Maluku for Malaria screening, RDT and ILLNs for pregnant women and children and GFATM funds for scaling-up the integrated MCH/MIP approach. However there is no indicator to measure this success. For future and current program planning and to strengthen monitoring and evaluation, it would be advisable adding strong output indicators for leverage, such as ensuring sustainable funding from the local government to support the program whereby action is required from UNICEF and USAID.
4. With the new budget allocation based on Village Law, villages in the remote area are encouraged to secure some funds to support transportation to refer emergency patients. Further formalizing the referral system at all levels is needed to ensure the roles of each level to stimulate their ownership through actions by UNICEF and DHO/PHO.
5. Given the fact that over 30% of the neonatal mortality happens at delivery and about 50% of maternal deaths are managed by a health professionals before death it is highly recommended that UNICEF develops a stronger focus on strengthening the basic integrated maternal/neonatal health services including safe deliver practices and neonatal resuscitation at Health Center/BEONC level instead of trying to cover the whole spectrum of Maternal and Neonatal health: Action required at UNICEF Country office level.

Selected lessons learned

1. Midwives at BEONC centers had a patient caseload below 100 deliveries per year. Below this international recognized standard, especially emergency delivery skills are eroding. As a result of the low caseload of midwives, a trained attendant is not necessarily a skilled attendant and there is no guarantee for a safe delivery / appropriate neonatal care.
2. When the under-funded MoH system is faced with budget cuts it is the supervision budget at all levels that seems to be sacrificed first. Lack of quality monitoring / supervision / feedback mechanism results, not only in low motivation of field staff and reduced service quality, but also in poor data collection which hampers evidence-based policy making and planning: these budget cuts come at a very high cost.
3. Integrating the MIP guidelines and introduced to the curriculum of medical/midwifery schools is an excellent way to ensure the continuation transfer of learning / knowledge related to the integration and production of high quality of health service providers.

1. Introduction and background

1.1. Introduction

Indonesia has a population of 238 million; is the fourth largest population in the world and is the largest economy in South East Asia. Extreme poverty fell from 23.4% in 1999 to 11.4% in 2013, while over 40% of the population or around 105 million are living on less than 2 US$ a day.[11] The Eastern Indonesian provinces rank among the poorest in Indonesia. Papua is the poorest of all Indonesian provinces ranking at 33, followed by West Papua (32), Maluku (31), East Nusa Tenggara (30) and West Nusa Tenggara (29); North Maluku is the exception in Eastern Indonesia ranking at 14 but still with about 10% of the population living below the poverty line.[12]

From 1990 to 2007 Indonesian reduction of Maternal Mortality (MDG 5) and of U-five mortality (MDG 4) figures showed a steady progress with having the largest reductions happening before the financial crisis and the decentralization. The hasty decentralization in 2001 has increased the difficulty of establishing coordinated national health programs and accounting for health funds and as a result may have contributed to the slowdown of U-five mortality and especially maternal mortality (MMR) reduction. Despite last years and current strong economic growth, significant health challenges remain: the progress on maternal health (MDG 5) has slowed down maternal mortality rate (MMR) (number of deaths among pregnant women / within 42 days after delivery per 100,000) declined from 390 / 100,000 in 1991 to 228 / 100,000 in 2007 and was in 2012 pegged at 359 / 100,000. Infant and child mortality (MDG 4) is currently 32 respectively 40per 1,000 live births. Especially the reduction of neonatal mortality rate (NMR) has stalled: still at the 2007 level: 19 deaths per 1,000 births.[13] This performance is, compared to other Asian countries, rather poor and as a result Indonesia will probably need a few more years to meet these MGD targets.[14]

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[11] World Bank. Indonesia Economic Quarterly - Slower Growth; High Risks2013: Accessed from: http://www.worldbank.org/content/dam/Worldbank/document/EAP/Indonesia/IEQ-Dec13-ENGLISH.pdf.

[12] North Maluku, Maluku, West Nusa Tenggara, East Nusta Tenggara, West Papua and Papua - Poverty - Percentage of Poor People, Rural [database on the Internet]. knoema.com. [cited September 8, 2014]. Accessed from: http://knoema.com/atlas/embed/Indonesia/North-Maluku/topics/Living-Conditions/Poverty/percent-of-Poor-People-Rural?compareTo=ID-MA,ID-PB.

[13] Indonesia - Demographic and Health Survey 20122013; Statistic Indonesia, National Population and Family Planning Board, Ministry of Health, Measure DHS, ICF International: Accessed from: http://dhsprogram.com/publications/publication-FR275-DHS-Final-Reports.cfm.

[14] Joint Committee on Reducing Maternal and Neonatal Mortality in Indonesia. Reducing Maternal and Neonatal Mortality in Indonesia : Saving Lives, Saving the Future. 2013.

In Indonesia, availability and quality of basic emergency obstetric and neonatal care (BEONC) is below standard: according to the 2011 Health Facility Review, by WHO and World Bank, about 60% of districts have less than the government's recommended 4 Health Centers providing BEONC. Shortages of drugs and supplies at Health Center level are common also for key commodities to address maternal emergencies.

Both health professionals and families have to deal with the harsh reality of poor BEONC services leading to maternal and neonatal death. According to the above-mentioned survey almost 25% of the Health Center in-patients, including patients in BEONC Health Centers, had no transport for referral. Service quality and rates of maternal and neonatal death are the poorest in the provinces of Eastern Indonesia and among the poorest women and children.

East Indonesia has a myriad of remote islands in Maluku, an extremely difficult highland terrain in Papua, and has a huge variety in quality of healthcare due to differing levels of commitment, availability and level of skills of health professionals in each district. Maternal and child mortality was, compared to the national average, always higher in Eastern Indonesia because of lower demand, a weaker health system, the geophysical challenges and the higher burden of infectious diseases, including Malaria. In East Indonesia the 3 leading causes of maternal mortality are: 1. Haemorrhage: 34% (including: post- and antenatal haemorrhage, placenta previa, and premature separation of placenta). This is higher compared to other Indonesian areas. 2. Eclampsia: 26% (including: edema, proteinuria, and hypertensive disorder). This is lower compared to other Indonesian areas. 3. Puerperium problems, mostly infections including Malaria (30%) (one of the highest compared to other Indonesian area's)[15]. Malaria is important in endemic areas, like Eastern Indonesia and can be responsible for maternal deaths both during acute malarial episodes and afterwards because of the effects of the disease on maternal anemia.[16] Most if not all of these maternal and neonatal deaths are preventable. About 50% of maternal deaths are managed by a health professional before death[17] while in a Malaria endemic situation up to 25% of the maternal deaths can be attributed to Malaria.[18,19] The medical factors that cause

[15] Ibid.
[16] Ibid.
[17] Ronsmans C, Scott S, Qomariyah SN, Achadi E, Braunholtz D, Marshall T, et al. Professional assistance during birth and maternal mortality in two Indonesian districts. Bull World Health Organ. 2009 Jun;87(6):416-23.
[18] Steketee RW, Nahlen BL, Parise ME, Menendez C. The burden of malaria in pregnancy in malaria-endemic areas. Am J Trop Med Hyg. 2001 Jan-Feb;64(1-2 Suppl):28-35.
[19] Schantz-Dunn J, Nour NM. Malaria and pregnancy: a global health perspective. Rev Obstet Gynecol. 2009 Summer;2(3):186-92.

maternal, fetal (stillbirth), and neonatal deaths are often the same and the causes of increased maternal, fetal, and neonatal mortality include poor nutrition, living in poverty, poor access to care, and poor quality of care. High risk of maternal death is strongly related to high risk of both stillbirth and neonatal death and interventions aimed at reducing maternal mortality will frequently reduce stillbirths and many neonatal deaths.[20]

Socio-economic, educational and cultural factors and the poor access to services due to the geographical setting, are problems beyond short time interventions. However, delays in recognition of a maternal/neonatal emergency, decision making and transport/referral: the classic "three delays" and the quality of services, can be targeted as we can learn from other countries who managed to reduce both maternal and neonatal mortality to the MDG targets in a rather short period of time span (5-10) years.[21,22]

East Indonesia has vast tropical forests, swamps, coastal marshes and shallow lakes and as a result this is a high Malaria transmission area (>1 case per 1000 population) and annual parasites incidence (API) between 10% (Lesser Sunda Island) and 15% (Papua).[23,24] Pregnancy weakens the pregnant women's immunity, increasing the risk of infection, severe anemia and death. Malaria in pregnancy results in hemolytic anemia and is often the cause of maternal death. Also acute renal insufficiency, spontaneous abortion and stillbirth are related to Malaria in pregnancy while Malaria infection of the placenta leads to low birth weight.[25] Globally Malaria case fatality rate in pregnant women varies from 13% in a stable epidemiological setting to 71% in a Malaria outbreak situation.[26] Malaria contributes at about 8% to the child's mortality[27] while fetal loss or neonatal death rate in a Malaria outbreak situation can be up to 67%.[28] In Africa where Malaria is endemic (Malaria Plasmodium only) it may directly contribute to about 25% of all maternal deaths.[29] Sub-Saharan African (SSA) interventions illustrate that 90% of the maternal Malaria burden can

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20 Joint Committee on Reducing Maternal and Neonatal Mortality in Indonesia.

21 Freedman LP, Graham WJ, Brazier E, Smith JM, Ensor T, Fauveau V, et al. Practical lessons from global safe motherhood initiatives: time for a new focus on implementation. Lancet. 2007 Oct 13;370(9595):1383-91.

22 Lazanoet. Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis. The Lancet. 2010;378:113-6.

23 WHO. International Malaria profiles: Indonesia Accessed from: http://www.who.int/Malaria/publications/country-profiles/profile_idn_en.pdf.

24 Elyazar IR, Gething PW, Patil AP, Rogayah H, Kusriastuti R, Wismarini DM, et al. Plasmodium falciparum malaria endemicity in Indonesia in 2010. PLoS One. 2011;6(6):e21315.

25 Manson's Tropical Diseases. 23 ed. Jeremy Farrar et all, editor. London: Elsevier Saunders; 2014.

26 Wickramasuriya. Malaria and Ankylostomiasis in the Pregnant Woman. Oxford.: Oxford University Press; 1937.

27 Hammerich A, Campbell OM, Chandramohan D. Unstable malaria transmission and maternal mortality--experiences from Rwanda. Trop Med Int Health. 2002 Jul;7(7):573-6.

28 Steketee RW, Nahlen BL, Parise ME, Menendez C. The burden of malaria in pregnancy in malaria-endemic areas. Am J Trop Med Hyg. 2001 Jan-Feb;64(1-2 Suppl):28-35.

29 Schantz-Dunn J, Nour NM. Malaria and pregnancy: a global health perspective. Rev Obstet Gynecol. 2009 Summer;2(3):186-

be reduced by a combined approach: preventive chemoprophylaxis/ intermittent preventive treatment (IPT) with Sulphadoxine-pyrimethamine (SP), and the use of long lasting insecticide treated bed nets (LLINs).[30] However the traditional IPT utilized in SSA is not applicable to Indonesia, because of the SP resistance and the fact that Indonesia has four species of human malaria parasites: P. Vivax is the predominant species except in Papua where P. Falciparum slightly predominates. P. Malariae and P. Ovaleare mostly found in the eastern part of Indonesia, Nusa Tenggara Timur and Papua. The current national treatment policy is Artemisin Combination Therapy (ACT) for pregnant women except for 1st trimester infections.

According to the 2012 IDHS in Maluku 87%, in North Maluku 90%, in West Papua 87% and in Papua 58%, received at least one check-up from public doctors, nurses, or trained midwives.[31] With this coverage level strengthening ANC service delivery through increased coverage of interventions like LLINs and IPT with ACT, will be an incentive for the use of other services such as delivery with the assistance of a skilled birth attendant. According to B. Hawley, a CDC specialist on Malaria in Indonesia "Combining the vertical Malaria program stimulates like a wedge the horizontal MCH program."[32] Integration of MCH/MIP also has a positive synergetic effect on the health professionals involved: they are stimulated to cooperate and to work as a team.[33] According to the WHO: using Malaria in pregnancy as an entry point to comprehensive maternal and child health services, seems to be a very sound approach because it will not only reduce the burden of Malaria during pregnancy but will also improve MCH outcome.[34]

The Government of Indonesia introduced in 2014 a national health insurance scheme, *Jaminan Kesehatan Nasional* (JKN), aiming to achieve universal health coverage by the end of 2019. In 2015-16, substantial financial resources will be channelled to over 68,000 villages through arrangements under the new Village Law (800 million to 1.4 billion Rupiah per village). Coming years the village will have authority over a much larger budget, which will lead to increased accountability and inclusive decision-making. Especially point 3 of article 74 of the Village Law: improving public services for village citizens in order to

30 WHO. A Strategic Framework for Malaria Prevention and Control in Africa: Accessed from: http://www.who.int/malaria/publications/atoz/afr_mal_04_01/en/.
31 Indonesia - Demographic and Health Survey 2012.
32 Personal comment during discussion with UNICEF country office staff, August 8 2014. Jakarta.
33 WHO Bulletin. Editorial. 2005 April;83(4).
34 WHO Global Malaria Programme. Malaria: Global Fund proposal development (Round 11) - WHO Policy Brief2011: Accessed from: http://www.who.int/Malaria/publications/atoz/Malaria_gf_proposal_dev_who_policy_brief_201106.pdf.

accelerate the realization of public welfare, offers opportunity to advocate for local funding of village level, strengthening of LOCAL maternal and neonatal preventive and care services.[35]

1.2. Background

In October 2010, USAID decided through a five-year grant and under the UNICEF Umbrella Grant, (Agreement GHA-G-00-07-00007), to continue support for control of Malaria in Pregnancy (MIP) in 5 provinces in eastern Indonesia. The intent of the program is to reduce Malaria-related maternal and child mortality in provinces facing the highest burden of Malaria in Indonesia and home to 15 million people living on about 700.000 km^2 and a population density of 0.05 persons per $km^{2.}$. Also in October 2010, the new maternal and child health (MCH) UNICEF project was funded to accelerate progress in reducing maternal mortality in 4 of the provinces supported by the MIP program. In 2012 the two separate projects: Malaria in Pregnancy (MIP) and the MCH (ACHIEVE) were combined into one project titled: Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia (MCH/MIP).This program expires in September 29, 2015.

The MCH/MIP program is in sync with both USAID and UNICEF's overall goal in supporting GoI in attaining the MDG 4,5 and 6.This integrated project covers past years activities of two separate projects and is measured against the same indicators. The integrated project is designed to enhance efficiency and alignment in the joint effort to strengthen GoI systems for greater coverage and quality of integrated MCH/MIP services in Eastern Indonesia.

The medical events related to maternal, fetal (stillbirth) and neonatal deaths are mostly strongly related but the factors behind the causes include poor nutrition, living in poverty, poor access to care, and poor quality of care.[36]

As stated above Malaria is endemic in Eastern Indonesia with particularly high rates in the provinces of Papua, West Papua, Maluku, North Maluku and East Nusa Tenggara. These provinces have 8% of Indonesia's population but over 70% of its Malaria cases.[37] In these specific target provinces, people still lack basic preventive measures, receive poor

[35] Republic of Indonesia, Village Law Number 6/2014, accessed from http://menpan.go.id/jdih/perundang-undangan/undang-undang.
[36] Joint Committee on Reducing Maternal and Neonatal Mortality in Indonesia.
[37] Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia revised 3-08-2013. USAID project document regarding incremental funding to immunization in collaboration with CDC. Jakarta2013.

diagnosis and inappropriate treatment and are highly mobile and Malaria is an important factor in maternal and newborn health. Survey data estimate about 20,000 deaths annually, although officially reported, deaths due to Malaria are relatively small.[38] The USAID-funded MCH/MIP project uses the single disease approach of Malaria, through leverage of Global Fund, to strengthen the efforts to improve MCH and health systems in the remote areas of Eastern Indonesia, supports and facilitates the MoH Malaria and maternal health sub-directorate's implementation of integrated antenatal care. Using Malaria control as a wedge to force improvement to health systems in the most remote parts of the archipelago is an effort to maximize indirect beneficial effects of the primary Malaria prevention tool the LLIN, to increase demand for both antenatal health care services and a kind of "quick fix" for rapidly decreasing the MMR in the target provinces.[39,40]

The Overall goal of the MCH/MIP program is "to accelerate Indonesia's progress towards attaining MDG5 in Eastern Indonesia, using Malaria control as a wedge to force improvement to health systems in the most remote parts of the archipelago". This goal is consistent with discussions with the Ministry of Health (MoH) on goals for the next several years, and is in line with both the US Government's Global Health Initiative and UNICEF's Country Program Action Plan, which aims for development of integrated Malaria control in all highly Malaria-endemic areas of the entire country of Indonesia and reductions in maternal and neonatal mortality in all communities. In order to counter major access and quality of service, monitoring, planning and evaluation, human resources challenges and the lack of community participation and accountability of service providers, the MCH/MIP project supports MoH at sub-national level to implement district/provincial-wide Malaria in pregnancy program by Malaria screening, IPT and distribution of LLINs to pregnant women visiting the firsts ANC, by improving reporting on maternal and neonatal mortality, the referral system and the quality of Basic and Comprehensive Emergency Obstetric and Neonatal Care and referral.[41]

The specific objectives of the MCH/MIP program are:

Objective I: Improve service quality.

[38] UNICEF Indonesia. Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia (MIP and ACHIEVE) - Seventh Progress Report (November 2013 - April 2014) May 2014.

[39] Ibid.

[40] USAID. Report on a joint evaluation of UNICEF's USAID-funded program to control malaria in pregnancy in Eastern Indonesia. Jakarta May 13, 2009.

[41] UNICEF Indonesia. Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia (MIP and ACHIEVE) - Sixth Progress Report (May 2013 - October 2013) November 2013.

This covers the following original ACHIEVE and MIP objectives:

- Objective 1.(MIP): Malaria in Pregnancy (MIP) services provided by midwives and nurses improved.
- Objective 2.(ACHIEVE): Ensure that all women and new-borns receive comprehensive and quality care during pregnancy, delivery and postnatal periods.

Objective II: Improve health management.

This covers the following original ACHIEVE and MIP objectives

- Objective 2.(ACHIEVE): Improve district health system management for maternal and neonatal health.
- Objective 3.(MIP): Quality monitoring and evaluation, and supervision at provincial, district, and health center level are implemented.

Objective III: Use of evidence for implementation.

This covers the following original ACHIEVE and MIP objectives:

- Objective 4.(ACHIEVE): Enhance management and coordination for policy advocacy and sustainable and effective program outcomes through sharing of experiences and good practices.
- Objective 4.(MIP): Support operational research in Indonesia related to the control of Malaria in pregnancy.

Project-specific objectives

There are two project specific objectives which are not re-formulated into new objectives of the project. They include objective 3 of MIP and objective 1 of ACHIEVE.

- Objective 3. (MIP): Integrated Malaria program coverage is increased within and among districts through advocacy and leveraging of local government/GFATM funds.
- Objective 1. (ACHIEVE):Improve the district based referral system to ensure accessibility of quality emergency care for women and newborns. There has been no indicator set for this specific objective. This reflects that improving the referral system has not been a focus for UNICEF in this project period.

For the remaining years it is expected that the USAID-funded and UNICEF implemented Maternal and Child Health and Integrated Malaria Control (MCH/MIP) in Eastern Indonesia project will continue the following activities.[42]

[42] Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia revised 3-08-2013. USAID project document regarding incremental funding to immunization in collaboration with CDC.

1. To support and sustain the control of Malaria in pregnant women and young children by strengthening management, coordination, advocacy, sustainable and effective program outcomes through sharing of experiences and best practices and replication/scaling up of integrated Malaria program coverage among districts through advocacy and leveraging of local Government/GFATM funds and government schemes.
2. To provide technical assistance to improve district-based referral systems to ensure accessibility of quality emergency care for women and newborns and to improve documentation and advocacy for needful policy and program formulation based on the evidence of current and upcoming initiatives.
3. To ensure that all women and newborns receive comprehensive and quality care including interventions to improve nutrition status of children and women during pregnancy, delivery and postnatal periods.

For the detailed list of expected project activities: see ANNEX I: Scope of Work, Purpose and Objectives of the Evaluation.

1.3. Scope of Work

The purpose of this mid-term performance evaluation is to assess UNICEF's progress towards their stated objectives and indicators in this project, and to make specific recommendations to improve the project's performance and to guide future programming.

Given the fact that the integrated MCH/MIP program is at a mid-term, there is a need to assess the project's progress; whether the program is well targeted and focused; in-sync and in line with current GoI strategies and actions towards the MDG's; increased its effectivity and finally to assess whether the program indicators still cover program activities, input, process and outcome.

USAID's and UNICEF's overall goal is to support the GoI's efforts regarding the MDG's 4,5 and 6. The results of the mid-term evaluation will provide these three key partners with information on the current "state of the project", which allows midcourse corrections and changes when needed and might guide future programming. The specific objectives of this mid-term evaluation are: 1) to assess the performance of the project against indicators and targets, 2) to make recommendations for the remaining years, 3) and to make observations and recommendations for current efforts or future programming with specific focus on the program indicators. Detailed expected project activities,

statement of work, purpose and objectives of the mid-term evaluation are listed in: ANNEX I.

These three specific objectives are translated into the following overarching evaluation questions:

1) What progress has been made towards the project's objectives of improving the quality of Maternal and Child Health and Malaria in Pregnancy programs, and replicating good quality programs broadly? How have UNICEF's inputs and efforts contributed to the Government of Indonesia's investments in Maternal and Child Health in Eastern Indonesia, such as the Island Cluster Approach?
2) Is the project appropriately targeted and focused in the breadth of what it does, and how it supports the GoI's efforts to improve Maternal and Child Health in Eastern Indonesia?
3) How scalable is the impact of UNICEF's interventions, and how replicable is their approach?
4) Are the project indicators accurately and sufficiently capturing the full scope of the project's impact? Are the indicators sufficiently specified and appropriately designed to measure the project's impact? If not, how can they be improved?
5) How successfully have the management and implementation of the two formerly-separate MIP and ACHIEVE projects been integrated into a single coherent effort, with a unified set of indicators and performance measures? How effectively do the two components achieve synergies and/or leverage each other for greatest impact?

2. Methodology

2.1. Overarching framework

The CDC Working Group on Evaluation has developed a comprehensive and step-by-step evaluation framework to improve and account for public health and curative actions as pictured in Fig 1 below.[43]

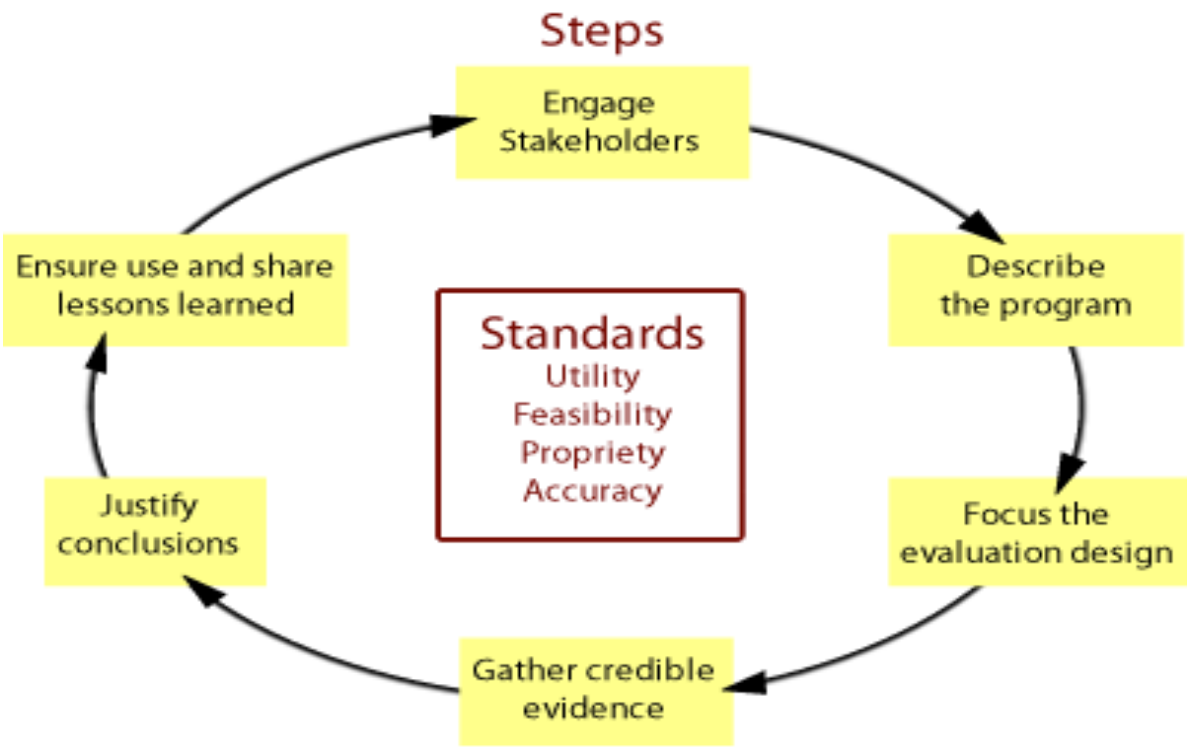

Figure 1. CDC Evaluation framework for public health and curative actions.

Evaluation in general involves procedures that are useful, feasible, ethical, and accurate: this CDC Framework for Program Evaluation in Public Health is a practical, non-prescriptive tool, which summarizes and organizes the steps and standards of an effective program evaluation. We use the above-mentioned CDC framework as a guideline for this mid-term evaluation process and to assess the MCH/MIP progress towards the program objectives. The Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia (MIP and ACHIEVE) has three objectives, which are related to both MIP and ACHIEVE original

[43] Framework for Program Evaluation in Public Health. CDC; 1999 [cited 2014 August 2]; Accessed from: http://www.cdc.gov/EVAL/framework/.

objectives. In addition, there are two project-specifics objectives: all summarized in Table 1. To asses whether these objectives are met, UNICEF in consultation with the partners (i.e. the government of Indonesia and USAID) set 22 performance indicators. The evaluation team involved UNICEF and stakeholders from province and district levels in the data collection process. This approach may introduce bias to the data collection, as beneficiaries might not want to inform the real situation in the presence of UNICEF and other health offices staff. However, by informing the stakeholders on the objectives and the bottom-up approach of the evaluation, which includes getting their recommendation and creating commitment for the future programming, we assume that the bias is limited.

New objectives	MIP objectives	ACHIEVE Objective
Objective 1: Improve Service Quality	Objective 1: Malaria in Pregnancy (MIP) services provided by midwives and nurses are improved.	Objective 2: Ensure that all women and newborns receive comprehensive and quality care during pregnancy, delivery and postnatal periods.
Objective 2: Improve Health Management	Objective 2: Quality monitoring and evaluation, and supervision at provincial, district, and health center level are implemented.	Objective 3: Improve district health system management for maternal and neonatal health.
Objective 3: Use of evidence for implementation.	Objective 4: Support operational research in Indonesia related to the control of malaria in pregnancy.	Objective 4: Enhance management and coordination for policy advocacy and sustainable and effective program outcomes through sharing of experiences and good practices.
Project-specific objectives	Objective 3: Integrated malaria program coverage is increased within and among districts through advocacy and leveraging of local government/GFATM funds.	Objective 1: Improve the district based referral system to ensure accessibility of quality emergency care for women and newborns.

Table. 1.Objectives of the Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia (MIP and ACHIEVE).

2.2. Time line, design, selection of sites and informants

The assignment started with the formation of the team and introduction of the team at USAID offices on August 8, and the final report was due on September 16, 2014. The overview of the Time Line and Deliverables is attached as ANNEX II, the Itinerary is

attached as ANNEX III and the list of informants as ANNEX IV. Discussions were conducted with UNICEF staff, as well as the PHO/DHO staff after field visits to clarify findings and to extract further information related to the issues discussed. The discussions were also used to share lessons learned right after the data collection in each site. For efficiency reasons the team sometimes split up some evaluation tasks. The team approach characterized this evaluation while team members had a specific task division as documented in ANNEX V.

The evaluation team combined quantitative and qualitative approach including data set comparison, documents review, interviews and focused group discussion as explained in the following chapters: data collection/instruments (2.3) and data process/interpretation (2.4). In sequence, the approaches were conducted as follow:

A. Desk-base study: review of project reports/documents data sets and other relevant documentation/literature before the start of the mid-term evaluation and during the first week in order to be introduced to the MCH/MIP program.
B. Interviews in Jakarta with MoH officials, UNICEF Country Office staff and representatives of other (non) USAID-funded programs in order to understand the context depth of the program and to assess progress, scalability and sustainability of the MCH/MIP program and the coordination/collaboration with other (non) USAID-funded programs.

   Site visits to three project areas during week 2 and 3 of the evaluation.

A) The evaluation started with a desk-study of relevant program documents. The team reviewed documents provided by USAID/Indonesia, and UNICEF/Indonesian Country Office, including the project SOW, routine UNICEF reports and other relevant documents related to specific Indonesian and global MCH and Malaria programs. The main objective of this document review was to compare program progress against the program indicators and targets, which is the first evaluation question. The documents review was also used to develop the data collection instruments for the site visits and interviews in Jakarta.

B) Discussions at UNICEF country office were held to get the overall picture of the program implementation, including the challenges faced, efforts taken to overcome challenges, and the program progress against the program indicators/targets. These discussions were also instrumental for the site selection. Interviews were also conducted with related MOH officers at national level to explore UNICEF inputs to the government

of Indonesia (GoI) and to assess whether these inputs are in sync and in line with the GoI policies. In addition, the discussion was also used to gather information on challenges for program implementation as well as the program sustainability.

The final site selection was conducted in consultation with UNICEF country office as well as with USAID staff. This selection was not at random, but it was designed purposively to get the specific information needed for the evaluation process. For example Maluku was selected to get specific information on the cluster islands approach, which was developed and implemented in Maluku. Papua and West-Papua were also selected for specific reasons, such as to understand the challenges faced by the program due to geographical barriers. The visit to Sorong was planned by the evaluation team to get a good picture of the program implementation in an area with high a prevalence of HIV/AIDS. The selection of sites to be visited took also in consideration the approach being used by UNICEF in providing the specific technical assistance like the use of the "positive deviance approach": model sites developed in some focused districts/health centers to be further adapted and implemented in other districts/health centers.

Once the sites were selected, the selection of informants to be interviewed by the evaluation team was in consultation with UNICEF field staff. Considering the limited time available, again, this also was a purposively selection approach. This may also introduce bias to the data collection process. However the data triangulation, by which the evaluation team gathers and combines quantitative and qualitative data from available data sources and from informants at all levels assures that the evaluation team gets the best possible picture.

The team interviewed 97 informants (as listed in ANNEX IV) including national and local level government staff, working at both policy and technical levels and USAID staff, UNICEF project staff, other (non) USAID program staff working in MCH and Malaria in Eastern Indonesia. The team also had discussions with 21 Health Center clients (in 3 focused group discussion of 5-8 clients). Overall, the Evaluation team met about 200 people both through the interviews and FGDs, and at the island of Nyafar Nifmas, (Maluku) where the team had a focus group discussion with 8 villagers and conducted an extended village gathering with 85 villagers.

2.3 Data collection and instruments

Based on the five core evaluation questions, as presented in the background chapter (1.3) an overall structural questionnaire (ANNEX VI) and specific interview guidelines, for MoH,

UNICEF Country Office, DHO/PHO, UNICEF Provincial Offices and clients were developed (ANNEX VII). Informants for each evaluation question were defined based on their relevancy to the questions; while methods of data collection were defined based on the possible number of informants willing to be consulted for the question.

The first evaluation question (the program progress against program indicators), for example, was answered by comparing the MCH/MIP program progress against Baseline 2010 and "National 2013 Performance" (meaning a compilation of routine quantitative performance data on the integrated MCH/MIP program indicators in all 5 provinces in Eastern Indonesia) and combined with results from interviews of UNICEF staff at country and provincial office level as well as discussion with beneficiaries in supported districts (qualitative data). The other evaluation questions will be answered based on the results from interviews with stakeholders using the specific interview guidelines (qualitative data) and combined with / compared against the results of the Baseline 2010-Results 2013 comparison.

2.4. Data process and interpretation

For the quantitative evaluation: measuring the MCH/MIP program progress on the objectives against established program indicators, the evaluation team selected the best available routine data set. In order to measure this progress the evaluation team opted for maximal reliability by comparing the most recent available performance data (National Performance 2013) against the 2010 baseline indicators: covering a timespan of over 3 years. As a result the evaluation team first developed an overall overview "Progress on Program indicators 2010 baseline - 2013 results" spread sheet (see ANNEX X), to facilitate the analyses of total progress over all indicators per province and the progress per specific indicator per province.

For the qualitative analysis: all interviews and focused group discussion, when possible and after consent, were audio-recorded. In addition, a matrix (by informant by question) was developed to put brief notes based on the finding from the interviews and discussions (see ANNEX VIII). Completion of the matrix was as much as possible conducted on a daily basis to avoid missing information. The findings presented in this report are based on the quantitative analysis and qualitative analyses of both the matrix and audio-records.

3. Findings

In order to fulfill the first specific objective of this evaluation: to assess the performance of the MCH/MIP project and the related overarching core questions (1.3): we start with paragraphs on progress against objectives and indicators followed by the paragraph on the UNICEF inputs and efforts. The next paragraphs describe the program focus and coherence, coordination and harmonization, integration and synergy of MIP and ACHIEVE, followed by the advocacy and leverage of GFATM and other funds, health system challenges and adaptation to MoH policy changes, monitoring and evaluation and ends with a description of sustainability and scalability.

3.1. Progress on objectives against combined ACHIEVE/MIP Indicators

For the quantitative assessment of the program, the evaluation team was supplied with 3 data sets: the first set included the combined ACHIEVE/MIP (MCH/MIP) program 2010 baseline/ target indicators 2011-2015, per province and two sets "National Performance 2012 and 2013": covering MCH/MIP program target indicators, results and percentages reached in the 5 Eastern provinces as compiled by UNICEF. However, comparing the most recent available performance data (national performance 2013) against 2010 baseline indicators posed a challenge because of the missing values in both data sets. In order to increase the strength (validity and reliability) of the comparison between the 2010 baseline and the 2013 performance indicators, missing values of the 2010 baseline indicators were imputed using agreed 2011/2012 program target indicators (as stipulated in ANNEX X). As for the "National Performance 2012" this data set has, compared to the 2013 data, besides missing values, also data reporting formats that do not allow comparison with the 2010 baseline.

Table 2 offers a summary of progress on overall indicators in 4 quartiles; respectively >/= 100%, 75-100%, 50-75% and </=50% of target reached and 1 category "undetermined". From this Table it can be concluded that for all provinces and over all indicators, 46% reached at 100% or beyond the targets/indicators (Maluku Utara 10, Maluku 8, Papua 12, West Papua 13, and NTT 8 of the 22 indicators) and 78% of the targets/indicators were reached at 50% or beyond (Maluku Utara 19, Maluku15, Papua 16, West Papua 14 and NTT 13 of the 22 indicators) over the 3-years timespan. All provinces have (3-8) missing values. Compared to the other 3 provinces, the provinces Maluku and

NTT are under-performing with respectively 7 and 9 of the 22 of the target indicators reaching 100% or beyond. Papua and West Papua seemed to be the high(-er) performing provinces, with respectively 12 and 13 of the 22 indicators having reached 100% or beyond, however especially the results of Papua need to be treated carefully because in 2013 only 14 of the 29 districts reported their results to provincial level.

Progress summary: Indicators reached	Maluku Utara	Maluku	Papua	West Papua	NTT
>/= 100% of target reached	10	7	12	13	9
75-100%	3	1	3	1	2
50-75%	6	7	1	0	3
</=50%	0	3	1	4	1
Undetermined	3	4	5	4	7

Table 2: Summary of progress (2010-2013) on overall indicators in 4 quartiles and 1 category undetermined across 5 provinces in Eastern Indonesia.

The USAID-funded and GoI/UNICEF implemented Maternal and Child Health integrated Malaria Control Program (MCH/MIP) in Eastern Indonesia is measured against the 22 core indicators listed in ANNEX X. These indicators are originally stemming from the MIP (Malaria in Pregnancy) and the ACHIEVE / Mother and Child Health programs which were merged together with the program objectives into the current integrated MCH/MIP program in October 2011.

Comparing progress against objectives and indicators (2010-2012) we refer to the 22 core indicators (refer to ANNEX X Progress on program indicators 2010 baseline - 2013 results). Overall one can observe that in all provinces selected parts of the service quality of MIP and MCH (indicators. 1-4) and for indicator 11, Maluku and Maluku Utara seem to perform very well. However in Papua, West Papua and NTT the number of districts with effective malaria slides crosschecking systems were very low. The malaria part of the program was strong in logistics (reduced stock outs: indicator 5-7, except for LLINs: 86% reported in Maluku and 0% reported in NTT) compared to MCH logistics (indicator 8-10), which were not reported at all.

Except the result of first ANC (MCH) visits (indicator 15) in Maluku Utara: over 100% of the targets reached and the first ANC (MIP) visit in West Papua (indicators 14 and

16) over 100% of the targets reached, the overall percentage of targets reached on ANC related indicators (indicators 12-17) seems to be low in the other provinces. On the advocacy indicator 18 there is a remarkable split: Maluku Utara and Maluku are reaching far beyond the 100% targets while the other three provinces are underperforming with percentages ranging from 25%-48% reached. The mother and neonatal care (indicators 19-22) seems to be weak in Maluku Utara and Maluku and strong in the provinces Papua, West Papua and NTT. In the following chapter a more detailed description about the performance against the project objectives and indicators is presented.

3.1.1. Objective I: Improve service quality

This covers two original objectives, one from ACHIEVE (objective 2) and one from MIP (objective 1). Table 3 below describes the performance against the objectives and indicators.

Objectives	Indicators	Findings
Objective 1 (ACHIEVE): *Ensure that all women and newborns receive comprehensive and quality care during pregnancy, delivery and postnatal periods.*	**Indicator1:** Number of midwifery academies with pre-service training module for midwives developed and implemented:	West Papua and NTT reached their targets while of the three other provinces some exceeded beyond their targets as illustrated below in Figure 2.
	Indicator3: Number of districts with standard localized model HC for internship for new staff:	Maluku Utara and NTT reached 200% of their target while the other provinces reached 100%.
	Indicators12&13: Proportion of pregnant women attending first ANC contact who receive screening and appropriate treatment (indicator 12: MIP, indicator 13: MCH):	All provinces except Maluku Utara reached below 75% of their targets on both MIP and MCH. Maluku Utara reached 84% on both MIP and MCH indicators.
	Indicators14&15: Proportion of pregnant women who attend ANC at least once during their pregnancy:	Maluku reached 39% of its target on indicator 14 (MIP). All other provinces reached well above 50% of their targets on both indicators. Maluku Utara reached over 100% on the MCH indicator (15) and Papua reached over 100% of target of respectively indicator 15 (MCH) and Indicator 14 (MIP).
	Indicator19: Proportion of pregnant women attending four	Maluku Utara and Maluku reached respectively 63% and 50% of their

	antenatal visits during their pregnancy:	targets while the other provinces reached 100% or beyond.
	Indicator 20: Proportion of delivery assisted by skilled birth attendances:	Maluku Utara and Maluku reached respectively 75% and 53% of their targets, while Papua, West Papua and NTT reached respectively 184,102, and 107% of their targets.
	Indicator 21&22: Proportion of newborns (Indicator 21) and mothers (Indicator 22) who received a check up by skilled health providers within 2 days of delivery (KF1 & KN1):	Maluku Utara and Maluku scored low on both indicators: Indicator 21 being 80% and 53% and for Indicator 22 being 74% and 62%. Papua, West Papua reached their targets on both indicators for 100% or more, while NTT reached 100% on target 21 and 92% on target 22.
Objective 2 (MIP): *Malaria in Pregnancy (MIP) services provided by midwives and nurses improved.*	**Indicator12&13:** Proportion of pregnant women attending first ANC contact who receive screening and appropriate treatment:	Maluku Utara reached on Indicator 12 (MIP) and 13 (MCH) 84% of its targets. West Papua reached on Indicator 12 (MIP) only 30% of its target while Papua did not report at all on indicator 13 (MCH). Provinces Maluku and NTT reached respectively 52% and 72% on both indicators. Papua reached 58% on indicator 12 and West Papua 57% on indicator 13.
	Indicator16&17: Proportion of pregnant women attending first ANC contact who receive an insecticide treated bed net:	Except Maluku Utara reached 69% of its target of indicator 17, the rest of the data are poor or under-reported due to the confusing definition of Indicator 17. On indicator 16 (MIP) Papua and West-Papua reached respectively 99% and 116% while Maluku Utara and Maluku reached respectively 69% and 35% of their targets on Indicator 16.

Table 3 Performance against Objective 1: Improve service quality

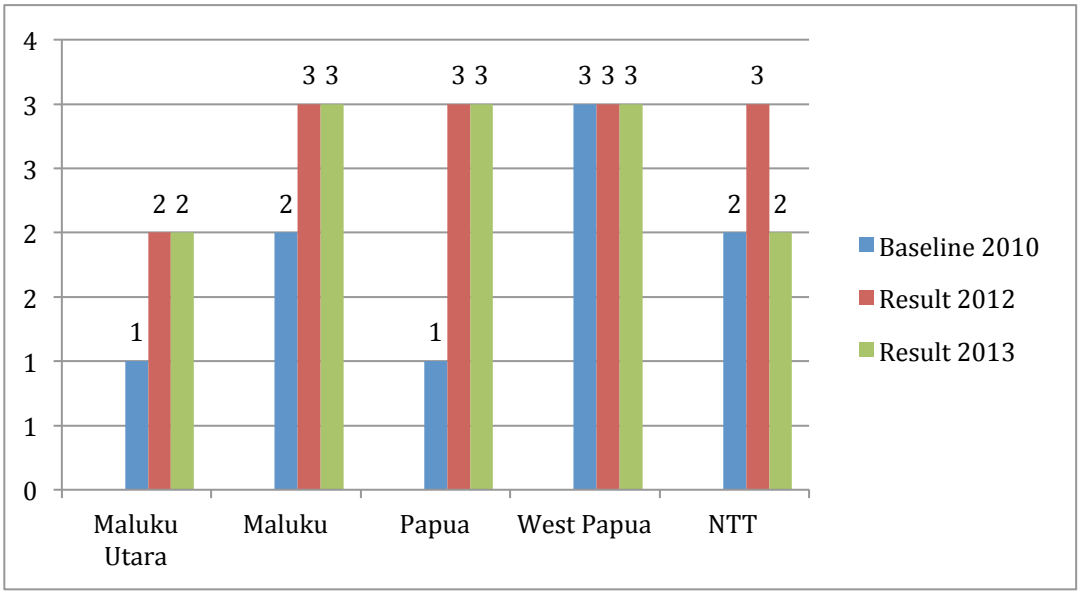

Figure 2. Number of midwifery academies with pre-service training module for bidans developed and implemented

3.1.2. Objective II: Improve health management

This new objective covers two original objectives:

1. (ACHIEVE): Improved district health system management for maternal and neonatal health.

2. (MIP): Quality monitoring and evaluation, and supervision at provincial, district, and health center level are implemented.

The performance of UNICEF activities against these two objectives is described below.

Objectives	Indicators	Findings
Objective 1 (ACHIEVE): *Improve district health system management for maternal and neonatal health*	**Indicators 5-10:** Number of Health Centers reporting no stock outs of essential items for the integrated Malaria program (ACTs, RDTs, LLINs) or maternal health program (magnesium sulphate, oxytocin, intravenous antibiotics) (MIP and MCH):	Due to lack of data available for Indicators 8,9,10, progress on these Indicators is undetermined. On Indicators 5, 6, 7: except the fact that NTT did not report and Maluku reached 86% on the MIP indicator 7 (LLINs), all other provinces reached 100% or more on indicators 5, 6, 7.
Objective 2 (MIP): *Quality monitoring and evaluation, and supervision at provincial, district,*	**Indicator 2:** Number of health centers in focus districts conducting quarterly midwife peer review meeting:	All provinces reached 100% or more on the targets of this indicator.
	Indicator 11: Number of	Maluku Utara and Maluku both

and health center level are implemented.	districts with effective malaria slides cross-checking systems:	reached over 100% of the targets of this Indicator. Papua, West Papua and NTT reached respectively 25%, 44% and 48% of the targets of this Indicator.

Table 4. Performance against Objective II: Improve Health Management

3.1.3. Objective III: Use of evidence for implementation.

This covers two original objectives, both are Objective 4 of the ACHIEVE and MIP program.

1. ACHIEVE: Enhance management and coordination for policy advocacy and sustainable and effective program outcomes through sharing of experiences and good practices. This objective is measured by Indicator 18, which is: 'Number of districts with budget allocation for integrated MCH program that is at least equal to the total contribution of the GFATM and UNICEF.' Only Maluku Utara and Papua reached 100% or more on the targets of this Indicator. Maluku and West Papua showed no progress and NTT did not report on this Indicator.

2. MIP: Support operational research in Indonesia related to the control of Malaria in pregnancy. UNICEF is an important partner of the CDC/LSTHM/Eijkman Malaria in MCH treatment trial. However there are no program indicators formulated to measure this objective.

3.1.4. Project-specific objectives

There are two project specific objectives which are not re-formulated into new objectives of the project. They include objective 3 of of the MIP and objective 1 of ACHIEVE program.

Objective 3 (MIP):Integrated malaria program coverage is increased within and among districts through advocacy and leveraging of local government/GFATM funds.

Three indicators were set for these specific objectives:

- Indicator 3: Number of districts with standard localized model HC for internship for new staff.
- Indicator 4:Number of health centers in focus district using mother card integrated with malaria for program monitoring:

- Indicator 18: Number of districts with budget allocation for integrated MCH program that is at least equal to the total contribution of the GFATM and UNICEF:

For Indicators 3 and 4, all provinces reached 100% or more on the targets. While for Indicator 18 only Maluku Utara and Papua reached 100% or more on the targets. Maluku and West Papua showed no progress and NTT did not report on this Indicator.

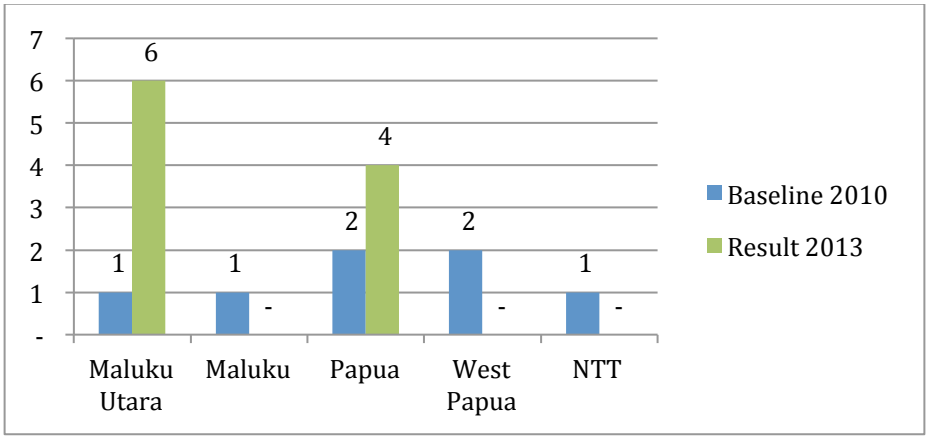

Figure 3. Number of districts with budget allocation for integrated MCH program

Objective 1 (ACHIEVE): Improve the district based referral system to ensure accessibility of quality emergency care for women and newborns. There has been no Indicator set for this specific objective. This reflects that improving the referral system has not been a focus by UNICEF in this project period.

3.1.5. Outcome Indicators

Two outcome Indicators were set by UNICEF and their partners to assess the project performance: number of neonatal deaths and maternal deaths (ANNEX X). The GoI routine health information was the source used for the number of maternal and neonatal deaths.

Maternal deaths: comparing number of reported maternal deaths in the year of 2012 and 2013 showed a decrease in Maluku and North Maluku, but an increase in Papua and West Papua. There were no data available on the performance in NTT in 2013.

Neonatal deaths: comparing data from 2012 and 2013, revealed a very high increase of neonatal mortality in North Maluku and West Papua: 72% and 62% respectively. However the neonatal mortality decreased in Maluku: 62% and in Papua 23%. Similar to

data for maternal deaths, there is no information available on neonatal deaths for 2013 in NTT. Given the fact that these figures are based on incomplete routine reporting data there is a possibility of over- and underestimation of the reported cases. As a result the data are too limited to derive a trend in maternal and neonatal mortality in Eastern Indonesia at this moment.

Given the complexity of the MCH/MIP program is facing in all three provinces visited: Papua, West Papua and West Maluku, the progress towards the objectives as measured by the Indicators is sufficient but stock-outs are still reported as can be learned from ANNEX X and the summary above. Especially the stock of LLIN seems to be a problem in Maluku province. Interview with the CDC Technical Advisor and the Director of the Sub-directorate Malaria confirmed that progress of the Malaria part of the program is hampered by problems related to procurement and distribution of LLIN at national level. As for MCH drugs and supplies, (Oxcitocin, Oxygen and Magnesium Sulphate) there seemed to be a logistical (late ordering) problem at District-Health Center level: there are no data available for Indicator 8-10. Staff at DHO/PHO level report that this is a temporary problem: "due to the electronic catalogue". Malaria progress is reported at provincial level but not covered by an appropriate outcome Indicator.

Moreover it is remarkable that the first objective: "to improve service quality" is covered by 10 indicators and objective II: "to improve health management" is covered by 11 indicators while objective III: "the use of evidence for implementation" is covered by only 2 indicators and the last objective: "to support operational research" has no Indicator at all. As a result of the above it is obvious that documentation of progress on Indicators needs to be addressed: Indicators are not balanced over the objectives. Objective I and II: "improving service quality and health management" have sufficient Indicators while objective III "Use of evidence for implementation" is not covered by appropriate Indicators.

The type and strength of the Indicators will be discussed in detail in the chapter below but in general the current targets and Indicators are mostly all at input and process level. The two outcome Indicators covering maternal and neonatal mortality lack resulting data to generate a solid conclusion: as a result, progress on these two outcome Indicators is undetermined.

The above-presented quantitative findings were confirmed during discussions with UNICEF staff at country office, regional office, and MoH partners and during field

observations. Summarizing the qualitative and quantitative information one could state: the progress towards objectives is gradual but slow, while most targets seem to be set realistic and progress towards the targets/indicators in 2013 was, compared to the 2010 baseline, as illustrated above good.

In general the integrated MCH/MIP program made a fair progress but given the weak health system, the extreme working conditions and logistical challenges in Papua, West Papua and Maluku, one could summarize the progress as follows "*Despite all challenges and barriers the USAID-funded and GoI/UNICEF implemented Maternal and Child Health Integrated Malaria Control program in Eastern Indonesia showed, compared to the 2010 baseline, a promising progress in the year 2013 but major challenges are still ahead*".

3.2. UNICEF Inputs, and results to strengthen MoH Malaria and MCH program

The inputs provided by UNICEF to the government of Indonesia in general can be summarized as 'strengthening the capacity' of the stakeholders from national to community level to implement the National Malaria Control Program and the National Maternity and Child Health program. According to some stakeholders there is no such thing like "The UNICEF Program". According to Dr E. Mulati from the Directorate of Child Health MOH, Jakarta, UNICEF acts as 'catalisator' to ensure that the Integrated MCH/MIP program is implemented appropriately.

The support to improve access and quality of Maternal and Child Health and Malaria in pregnancy programs is provided through technical assistance strengthening the health system and improving the capacity of the health providers often through the following 3 specific UNICEF approaches:

A. Maternity Waiting Homes or *Rumah Tunggu* (MWH) are a well tested and equity-based strategy implemented by UNICEF for the first time in Afghanistan about 20 years ago to increase access to maternal and newborn services among women from remote areas. It is a low-cost solution to skilled birth attendance, aiming to bridge the geographic gap in obstetric care in inaccessible areas and reduce inequities. To document the maternity waiting home approach, MoH and UNICEF have reviewed this approach[44]. As a result of this review, MoH decided on 15 August 2013 to start a well monitored try-out of the

[44] Evi Martha and team. A Review on Maternity Waiting Homes Effectiveness in 5 Provinces in Indonesia. Depok2013.

MWH approach in Banten Province before giving the green light for development of MWHs in 5 provinces: Jambi, Gorontalo, Maluku, West-Maluku, and NTT. According to some informants there seems to be no funding available for the evaluation of this try-out and as a result the official status of the MWH approach is currently not clear.[45,46,47,48]

B. Cluster Island Approach (CIA) was originally developed as a national economic planning process by BAPENAS (National Development Planning Board). The CIA was modelled as a health-planning tool for Maluku Tengah Barat (MTB) district to address access to health services, which are the major bottleneck in the Maluku's and Papua.

C. Integrated Micro Planning (IMP) is a technical capacity and advocacy approach initially developed by UNICEF in Aceh Province for Health Center level "bottom-up" planning. Through the IMP process, which includes a simple computerized data analysis process, Health Center staff is guided to find priority problems and planning activities for each village based on the problems found. IMP contributes to formulation of a district strategic plan based upon minimum service standards and is used to re-socialize the MCH, malaria and immunizations programs to professionals, stakeholders and policy makers. In Papua Province IMP has continued to serve as a vehicle to improve BOK (local funding mechanism) utilization rate and to contribute towards activities to reach underserved populations.[49]

The last two Technical Assistance tools proved to be useful in strengthening the local health system through facilitation of local planning of MCH/MIP programs/activities, including logistics/procurement, reporting and advocacy to the local government to ensure their support to the MCH and MIP programs.

To strengthen the health system, UNICEF facilitates ao:

1) Health centers conducting quarterly midwife peer reviews development.

2) Development of a standard localized model Health Center for internship for new staff.

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45 GoI MoH. *Pertemuan Kajian Efektivitas Rumah Tunggu Kelahiran*: Accessed from: http://www.gizikia.depkes.go.id/pertemuan-kajian-efektivitas-rumah-tunggu-kelahiran/?print=pdf.

46 Innovative Approaches to Maternal and Newborn Health Compendium of Case Studies, 2013: Accessed from: http://www.unicef.org/health/files/Innovative_Approaches_MNH_CaseStudies-2013.pdf.

47 Evi Martha and team. A Review on Maternity Waiting Homes Effectiveness in 5 Provinces in Indonesia. Depok2013.

48 UNICEF. Annual Report 2012 for Indonesia, EAPRO, : Accessed from: http://www.unicef.org/about/annualreport/files/Indonesia_COAR_2012.pdf

49 UNICEF Indonesia. Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia (MIP and ACHIEVE) - Seventh Progress Report (November 2013 - April 2014).

3) Implementation of mother card integrated with malaria for program monitoring, respectively Indicators 2, 3, and 4 all reaching 100% or beyond as presented above.
The USAID/UNICEF logistical support proved to be especially strong in the MIP part of the integrated program as illustrated by the Indicators 5.6.7 that reached 100% and more in all provinces (except Province Maluku on Indicator 7). MCH logistics are still a major challenge because none of the provinces reported on the related Indicators.

In order to ensure integrated MCH/MIP capacity at pre-service level, UNICEF has successfully developed and advocated implementation of integrated MCH/MIP training curriculum in medical schools and midwifery academics as is measured by Indicator 1, which reached beyond 100% of the target Indicators in all provinces.

Despite current logistical / procurement LLINs problems and in lesser degree of supply of Rapid Diagnostic Malaria Tests (RDT) reported by several informants including UNICEF and DHO staff, the LLIN coverage with support from GFATM is (except in Province Maluku) in all other provinces realizing 100% or more their targets. However, scaling-up beyond GF supported districts in highly endemic Eastern Indonesia (most of Papua, the Maluku's, and East and West Nusa Tenggara) is hampered by financial constraints. Quality LLINs have to be imported until now. The purchase of LLINs with GF support cost is less than $5 per net if free of tax. If purchased with MoH funds, the cost more than doubles due to tax[50].

The Integrated MCH Malaria program has been implemented beyond the UNICEF focus districts. In Indonesia vaccination is a very important part of the ANC program. Integration of the MCH and Malaria opens the door for further integration of the EPI program into the MCH/MIP program. Provision of bed nets seems to have improved the overall attendance of at least the first ANC visit in South Halmahera, district measles vaccination increased 10-15% against baseline data and in Jayapura district a 10% increase in routine ANC visit was observed in the year after the initiation of the integrated program UNICEF according to a UNICEF report.[51]

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50 WHO Jakarta. Review of the National Malaria Control Programme of the Republic of Indonesia. 2011; (September): Accessed from: http://apps.who.int/iris/bitstream/10665/94367/1/2012-08_SEARO.ReviewMalariaControl%20Prog.Indonesia%20201.pdf.

51 UNICEF. Sharpening the equity focus: Selected Innovations and lessons learned from UNICEF-assisted programmes 2009-20102011.

3.3. Program focus and coherence

The Malaria in pregnancy program is well focused with clear targets (screening of Malaria and LLINs for all women during their first ANC visit). This is also the case for the integration of Malaria control program with immunization for infants (providing bed nets for all infants after their last immunization visit for measles).

The Evaluation team noted during field visits that LLIN procurement/logistical and regular stock-outs of essential MCH supplies and drugs were the major constraints to the implementation of the MCH/MIP and immunization program. According to Dr. Asik Surya, Sub directorate Malaria, the implementation of the USAID/UNICEF supported integrated MCH/MIP program in Eastern Indonesia is in line with the National Malaria Control program policy.

To facilitate cooperation and collaboration between all MoH levels, UNICEF played an important role (shuttle diplomacy) in bringing together the MOH departments at central, provincial and district level. USAID/UNICEF, together with WHO, along with key officers within the MOH (especially Dr. AsikSurya, Head of the Sub-directorate Malaria, Dr. Lukas Hermawan, Head of the Sub-directorate Pregnant Women and Dr. Erna Mulati, Head of the Sub-directorate Child Health) who championed the benefits of integration, played critical roles in facilitating collaboration across the involved departments (Malaria, maternal health, immunization) to identify mutual goals, to draft a national strategy and to ensure joint inputs with regards to developing operational guidelines, training materials, staff orientation, logistics systems and new reporting formats for their respective programmes. The success of the integrated program, which managed to lever over 169 million US$ from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and is now rolled-out beyond the focus of Eastern Indonesian, is a good illustration that the program efforts and results are well appreciated.

Considering the specific geographical setting in Maluku, UNICEF helps the local government in formulating the Cluster Islands Approach: a tool "par excellence" that helps to develop a focus and coherent health planning. UNICEF assists the local DHO with the Cluster Island Approach to build the capacity of the health providers in selected Health Centers to become as '*pusatgugus*' or 'center of cluster' and to strengthen some district hospitals to become the referral CEONC hospital. Problems with human resources and logistics will remain but the approach suits the condition in Maluku well according to DHO

staff in Ambon. Health providers need enough number of cases to maintain their skills. From the field visit it is found that in some Health Centers the number of estimated deliveries per year is very small compared to the number of midwives working in the area. In the BEONC Aimas Health Center the average caseload per midwife was 7 deliveries maximum per month: too low to maintain essential emergency skills. According to Dr. Sudhir Kanal, the Papua-based UNICEF Child Survival and Development Specialist, the Cluster Island Approach could solve the problem of low caseload of midwives in Eastern Indonesia by determining the number and place of BEONC locations based on midwife caseload and need instead of blindly following the MoH instruction to develop the 4 standard BEONC sites also in low population density districts. Improving access should be in line with maintaining quality of care.

3.4 Coordination and harmonization with other (non-) USAID funded activities

USAID is a major donor for maternal and neonatal health. AusAID through their Australia Indonesia Maternal and Newborn Health and Nutrition Program (AIMPNH) in 10 districts in NTT province, is the other main bilateral donor in the field of maternal and neonatal health.[52] The USAID-supported JHPIEGO-contracted Expanding Maternal and Neonatal Survival (EMAS) program focuses on CEONC level in East Java and the USAID-funded Millennium Challenge Corporation (MCC) program aims to reduce stunting by integrating maternal and child health, nutrition, water and sanitation through the GoI. Beside UNICEF, WHO and UNFPA are other UN agencies providing maternal and neonatal technical assistance to the GoI.

At national level, coordination and harmonization with other (non)-USAID funded activities is realized through regular donor meetings coordinated by the MoH and high-level inter-donor coordination at donor's initiative.

At provincial level, the coordination meetings between development partners are through the existing provincial government and the Bappeda donor coordination secretariat. At this level program representatives of the integrated MCH/MIP program meet with AIMPNH representatives and also with the USAID-funded and RTI contracted Kinerja program professionals. Kinerja builds capacity at the local (or sub-national) level to improve accountability and measurable enhancements of health, education and business

52 DFAT Concept Note Accessed from: http://aid.dfat.gov.au/business/Documents/mnch-conceptnote-indonesia.pdf

development programs, managed and delivered by local service providers. Kinerja's focus in Papua is exclusively on health service delivery: strengthening leadership and management capacities for health service delivery. However according to several informants the current collaboration between Kinerja and UNICEF is sub-optimal: especially alignment of their specific activities, given the comparable mandates, needed to optimize USAID return of investment in Papua province.

In Maluku there is no other NGO working in the MCH/MIP field, GFATM is the only international donor active for health programs; UNICEF coordinates along with PHO closely every time needed. Professional communication lines between the GFATM representatives Thomas Matulessy, a retired PHO officer, and UNICEF office proved very short during the discussion the evaluation team had in Ambon on August 18 with the PHO team, UNICEF and the GFATM representative. The GFATM representative and PHO staff meet on a regular base to coordinated, synchronized activities and planning and support each other in implementation and evaluation of the integrated MCH/MIP program according to Dr. Olivi Silalahi, the UNICEF Malaria and EPI officer stationed in Ambon. As for non-health related NGOs and donors, usually the coordination is in the hands of Bappeda Province but since the last few years there are no other NGOs and donors active in Maluku.

In West Papua, a development partner forum has been formed to align NGO's working in this booming province. UNICEF and other organizations are waiting for the governor's signature to approve this partner forum. As mentioned by Dr. Victor Nugraha putra from the West Papua PHO, this partner forum is urgently needed to improve the dialogue and to cope with the challenges of MoH-NGO coordination (current frictions between MoH and Clinton Foundation illustrate the need for this platform).

In Papua, UNICEF was the driving force behind routine quarterly meetings in the provincial health forum, which was usually held by BAPPEDA. The head of the PHO confirmed that they just formed the partnership forum on June 1, 2014 and that NGO's and donors are looking forward.

3.5. Integration and synergy MIP and ACHIEVE

The integration of the two formerly separated programs is successful given the fact that comparing Baseline 2010 with results of 2013, over half of the Indicators reach 75% or

more of their target Indicators. Integration and synergy are especially visible at first line level of the health system. Midwives at Health Centers and villages have adopted the integrated Malaria approach. The integration of the two programs has stimulated teamwork and task sharing at Health Center level. Guidelines have been developed, staffs are trained and the curriculum is inserted in the medical/midwifery curriculum. Screening, treatment for Malaria and the distribution of LLIN are now part and parcel of the ANC package.

At national level, senior informants mentioned that there still is room for improvement of the coordination between DG in MoH but that new roles of two DGs (CDC and MCH) gradually developed while working together. In the last years the integrated program is running, a "specialization" has developed: The CDC/Malaria department mainly deals with the policy and the logistics for the integrated program, while the MCH department proved to be effective in operations and monitoring, especially in ensuring the quality of the services provided by health providers. However, review of the existing recording and reporting systems, more specifically the development of integrated Indicators is needed to ensure that the results of the integrated program are captured in the system in the future.

3.6 Health system challenges and adaptation to MoH policy changes

UNICEF is currently facing one main challenge in supporting the government of Indonesia through the MCH/MIP program: in the new Fund Channelling regulation, UNICEF cannot directly provide funding to the provincial and district government. There are two new government regulations related to fund channeling mechanisms, both were launched in 2012. The first regulation is called:*Peraturan Pemerintah (PP) nomor 2 tahun 2012 tentang Hibah Daerah* (the Government Regulation on Funding/grant to local governments) and the second is:*Peraturan Menteri Keuangan (PMK) nomor 188 tahun 2012 tentang Hibah dari Pemerintah Pusat kepada Pemerintah Daerah* (the Ministry of Finance regulation on funding from the central government to the local government). PP number 2 2012 implies that in providing funding to local governments, development partners should channel the funding through the central government, i.e the Ministry of Finance which acts as the countries general finance (*Bendahara Umum Negara*) body.

At national level, the challenges include the limited number of staff that has to deal with the administration for the funding provided by UNICEF in each province/district. To overcome this problem, UNICEF, together with the local government, channels the funding through third parties, such as professional organizations, local NGOs etc. However, this road has challenges of its own: sometimes it is difficult to find the third party, which has the technical and administrative capacity to manage the support. These problems have delayed the implementation of some activities in most areas.

3.7 Monitoring and evaluation

Monitoring, evaluation and feedback mechanism are key to the quality of the health service. The field visit to Papua, West Papua and Maluku revealed that monitoring and evaluation remains a problem for all staff at health center level. The facilitative supervision, the main supervision method, introduced many years ago by the MoH, has not been implemented because of lack of funding for the field visit according to a DHO staff member in Maluku. Also in Papua and West Papua there was no budget for supervision visits, because the allocated budget was the very first item to be slashed when DHOs were confronted with the national budget reductions last year. UNICEF staff and representatives from other NGO's were reluctantly taking the role of supervisors according to Vince Bakker, Head of the Malawe Health Center in Sorong. The evaluation team also found that there has been no post-training evaluation after UNICEF facilitated a team of health providers trained on BEONC in West Papua. Only West Maluku and Maluku have an effective malaria slide cross checking in place (Indicator 11). The feedback mechanism for Malaria quality control and evaluation is lacking in the other 3 provinces as illustrated by the microscopist at Mayamuk Health Center, West Papua: he never got feedback from the cross checker at district level on the results of the slides he submitted for cross checking.

The problem of lack of monitoring and evaluation (and the resulting detrimental effect on the quality of services) is admitted by Dr. Lukas Hermawan, Head of the Sub-directorate Pregnant Women: modules, SOP, guidelines are developed and distributed, health providers are trained, however there has been no effort to monitor the compliance of the health providers in using the modules, where ideally monitoring, evaluation and feedback should be standard practice in all levels of the Indonesian health system.

3.8. Sustainability and scalability

UNICEFaims at realizing sustainability and scalability of the MCH/IMC project by:

1. Successfully promoting the inserting MIP in the curricula at medicine/midwifery schools. This is one of the efforts to ensure that new health providers will have the skills and knowledge needed to provide integrated Malaria and MCH services (Indicator 1: over 100% of the targets reached in all provinces).

2. UNICEF also assists the provincial and district health offices to advocate the provincial and district government to ensure their support to the integrated MCH/MIP program: however only 2 of the 5 provinces reached their targets on Indicator 18.

3. The Cluster Island Approach has been implemented by the province government (they put it in the Regional Long Term Development Plan (RPJMD) and also by the central government to be used in other provinces with a similar geographical condition like Maluku. At district level, in Maluku, the Maluku Tenggara Barat district government has formalized the Custer Island Approach as a *Peraturan Daerah* (District regulation) to ensure continuation and budget allocation for the approach in the future.

4. The MWH approach, successful in other countries, and currently under evaluation by MoH is well established in Maluku and being scaled-up in West-Paua. The team has visited three homes, 2 in Maluku and 1 in West Papua, which were all in use, in a good shape, staffed with Kader, supervised by Health Center staff and maintained using district health funds. However as a result of the pending Indonesian evaluation of MWH, there are still no guidelines to facilitate the further scaling-up of this approach.

In order to ensure the sustainability of the integrated MCH/IMC program for a longer period, further assistance to the provincial and district health office is still needed, as the commitment of the district government to support the program in some districts is still sub-optimal. As an example: the support provided by UNICEF to one hospital in Papua to become a referral hospital for neonates, through facilitation of a training team from RSCM (the top referral hospital in Jakarta) has not been supported optimally by the local government to ensure the availability of the logistics needed.

Results of interviews with many stakeholders in Maluku and Papua stress the fact that there is progress but that reaching sustainability in Eastern Indonesia takes more time. One informant said that they are still in a premature phase: "If there is no support from UNICEF some of the programs may not be sustainable". Another informant mentioned

that to sustain the program, assistance from UNICEF is still needed especially for the non-focus districts. The integrated MCH/MIP program proved to be scalable through GFATM and the routine funding especially for Malaria control program is already available in 2 of the 3 provinces (Indicator 18) through the local government budget (APBD).

4. Recommendations

This chapter is divided into 3 paragraphs: paragraph 4.1.gives recommendations for the remaining years; paragraph 4.2.shares observations and recommendations for future programming and finally paragraph 4.3. The recommendations and action required by selected stakeholders is summarized in ANNEX XI. Further chapters discuss program's contributions towards USAID's higher-level health indicators. To align with the UNICEF objectives, recommendations are ordered based on their related objective whether it is to improve service quality, improve health management, or to use evidence for evaluation. Every recommendation is concluded with a required action by one or more of the stakeholders.

4.1. Recommendations for the remaining years

4.1.1. To improve service quality:

- Health Center staff implementing the integrated MCH/MIP program, including skilled attendants, will meet their limitations when there is lack of essential drugs and supplies and when accessibility of emergency services like caesarian section is not available. It is recommended that UNICEF advocates for a buffer stock at DHO-PHO level for Oxytocin, Magnesium sulphate, RDT and ACT and LLINs, and increases its efforts to strengthening the referral system and the quality of BEONC sites: Action required by UNICEF and DHO/PHO level.
- In Maluku, UNICEF has successfully piloted the MWH. The MWH offers a home close to an established BEONC/CEONC site for pregnant women in the last month of pregnancy, who cannot travel the distance between their home and the BEONC/CEONC site in case they need emergency maternal services. A first qualitative study commissioned by MoH and UNICEF illustrated the MWH approach. MoH has decided on August 15, 2013 to start and evaluate a try-out of MWH in Banten Province before giving green light to scale-up this approach. The progress of this try-out needs to be followed up: Action required by UNICEF at National level.
- Midwife density and the output of AKBIDs in both Maluku and Papua seem to reach saturation: it is advisable to reduce the intake of student at the midwifery school, otherwise they will become midwives who attend deliveries at home and are ill

prepared for emergency obstetric and neonatal services, while their services are counterproductive and will not contribute to the reduction of MMR and NMR. It is proposed to advocate in Papua and Maluku for a reduced intake of new midwives through a "numerus-clausus" system, to re-certify midwives having a caseload lower than 100 deliveries per year and to promote "4 hands delivery": Action required by National MOH level together with professional Organization (IBI).

- The successes of the LLIN, Malaria screening and treatment, in terms of increased first ANC visit and increased immunization figures, probably does not contribute much to increase the proportion of deliveries assisted by skilled midwives. It is recommended to use the synergy obtained by the integrated program to inform expecting mothers of the benefits of the JKN health insurance scheme, and to promote skilled delivery at an official BEONC site: Action required by UNICEF at DHO level.
- Maintaining the gains and momentum of the Integrated MCH/MIP approach: urgent action is needed: refresher and new training of health professionals to counter staff rotations and to improved facilitative supervision by MoH staff to maintain these skills and ensure quality of services: Action required by UNICEF at DHO level.

4.1.2. To improve health management:

- In "the ideal health setting" information gathered through a routine data collection system is translated into knowledge, which feeds rational national- and sub-national program planning and policymaking, improves health management and fuels advocacy for program expansion. In order to monitor, evaluate, document and demonstrate effectiveness of the GoI-implemented and USAID/UNICEF supported MCH/MIP program in Eastern Indonesia, improving the current routine data collection system and development of specific indicators to measure the results of the integrated approach of MCH/MIP program, is needed. Action required by UNICEF/DHO/PHO level.
- The integrated MCH/MIP program is well developed, aligned with the government program and well implemented. UNICEF has proven to be very successful in leverage of other funds like APBD funds in Maluku and North Maluku for Malaria screening, RDT and LLINs for pregnant women and children and GFATM funds for scaling-up the integrated MCH/MIP approach. However, there is no Indicator to measure this success. For future and current program planning and to strengthen monitoring and evaluation, it

would be advisable adding strong output Indicators for leverage, such as ensuring sustainable funding from the local government to support the program.
Action required by UNICEF and USAID.

4.1.3. To use evidence for evaluation

- In order to better bridge evidence and practice it is recommended that UNICEF strengthen its evidence-based health programming and documentation by increasing operations research (plus budget), systematic documentation and sharing of qualitative and quantitative results on the contextual conditions and the effect of intervention programs. Documentation can be realized through sharing lessons learned at (inter-) national professional level (conferences, workshops, blogging and peer-reviewed publications), development and dissemination of policy briefs and publications beyond the grey literature level of internal donor reports. Action required at UNICEF Country Office level.
- Performance Indicators of the MCH/MIP program are mostly at input and process level and use the data from the routine system or from specific records of UNICEF activities. The MCH/MIP program lacks program outcome Indicators. It is recommended to make program performance more tangible and focused by adding outcome Indicators, based on agreed National Indicators for both Malaria and MCH: Action required at UNICEF/MOH/USAID level.
- Both routine data and surveys (e.g. Indonesia Demographic and Health Surveys) show that progress has been made in increasing the coverage of several key reproductive, maternal, newborn and child health interventions[3]. However, there has been limited progress in improving maternal and child outcomes because of a major gap between coverage and the quality of care provided in health facilities. Therefore, it is important to make quality of service into an integral component of scaling-up interventions to improve health outcomes of mothers, newborns and children. Considering this, the WHO organized consultation on improving measurement of the quality of maternal, newborn and childcare in health facilities. The consultation proposed nineteen global core Indicators for assessing the quality of health care provided to mothers, newborns and children in health facilities (see ANNEX XII). It is expected that UNICEF supports GoI in selecting the appropriate Indicators as well as finding the mechanism to measure

them. As seen in the table attached, the Indicators can be captured through routine data collection, self-assessment or surveys. The existing facilitative supervision should be revitalized, as it is one of the main mechanisms to ensure quality of services and data collected to measure the progress against agreed-on Indicators: Action required by UNICEF and MOH at National/Provincial and district level.

- Despite regular stock outs, of ACT, RDT and LLINs in Eastern Indonesia, harboring about 80% of the Malaria incidence, the Indonesian Malaria control program is successful: according to the WHO World Malaria 2013, the number of presumed and confirmed cases is rather stable from 2010-2012: around 2 million a year (2010: 1 963 807 cases; in 2011: 2 384 260 cases and in 2013: 2 051 425 cases) while the number of confirmed cases goes down (2010: 465 764 cases, 2011: 422 447 cases and in 2013: 417 819 cases): a 4.4% reduction of confirmed cases over 3 years.[53] In order to keep the momentum and prepare for Malaria elimination (in line with the WHO/GOI Elimination target in 2030) the integrated MCH/MIP program should adopt a new Indicator 'proportion of villages reducing their endemicity level'. In addition, an output Indicator, e.g. number/percent of pregnant women with presumed/confirmed and treated malaria is advisable. Action required by UNICEF, USAID and MoH.
- Donor collaboration, cooperation and harmonization are an important efficiency requirement in development cooperation. In Papua province the USAID-funded and RTI contracted Kinerja project focuses exclusively on health service delivery: strengthening leadership and management capacities for health service delivery. Kinerja and UNICEF have overlapping mandates and focus. According to several informants the current collaboration between Kinerja and UNICEF is sub-optimal: especially alignment of their specific activities is needed: Action required by USAID/UNICEF.

4.2. Observations and recommendations for future programming

- UNICEF facilitates BEONC service level as observed by the evaluation team in Adaut, Maluku and Aimas Health Center in Sorong. At Yowari Hospital in Sentani, Papua province, UNICEF supports the neonatal health services. In Maluku, UNICEF, as part of the cluster island approach, supports the CEONC (PONED-Plus) facility at the Magretti

[53] World Malaria Report - Indonesia2013: Accessed from: http://www.who.int/malaria/publications/country-profiles/profile_idn_en.pdf?ua=1.

hospital in Saumlaki. Given the fact that over 30% of the neonatal mortality happens at delivery and 50% of the maternal mortality happens at service delivery level, it is highly recommended that UNICEF has a stronger focus on strengthening the basic integrated maternal/neonatal health services including safe delivery practices and neonatal resuscitation at Health Center / BEONC level instead of trying to cover the whole spectrum of Maternal and Neonatal health: Action required at UNICEF Country office level.

- Appropriate and professional decision making to reduce maternal and neonatal mortality starts with collection of high-quality data on the relevant rates and causes of mortality. Due to the decentralization, routine data collection and reporting in the Indonesian health system has eroded. National and regional planning often is based on the limited information of periodic household surveys to obtain official MMR and NMR figures. The evaluation team was provided with national performance data, however the spreadsheets had a lot of missing values (blank cells). The 2012 National Performance data sheet used different reporting formats (proportions instead of numbers) compared to the 2013 National Performance data sheet while for 2013 only 14 of the 29 districts in Papua submitted their reports to provincial level. Lack of appropriate program data hampers MONEV and ultimately program planning. A combination of Integrated Planning and Facilitative Supervision could be effective to improve quality of care, MONEV as well as to guide program planning in all Papuan and Maluku provinces: Action required at UNICEF/National/PHO/DHO level.

4.3 Measuring programs contributions towards USAID's higher-level health indicators

The goal of the current Indonesian Global Health Initiative (USAID) country strategy 2010-2014 for Indonesia is "Improved Health Impact through Collaboration" which will be achieved with concentrated efforts in three interrelated focus areas:

1. Catalyze action to accelerate Indonesia's progress towards achievement of Millennium Development Goals (MDG) 4, 5 and 6. Achieving the MDGs is a very high priority for the GoI. There is recognition that aggressive action will be required to meet MDG 5 in particular.
2. Enhancing the use of quality research and evidence in policy and programming, including introduction and adoption of new technologies and capacity building.

3. Partnering with the GoI to address regional and global infectious disease threats and strengthen Indonesia's engagement and leadership in regional and global health issues and fora.

According to the evaluation team, all UNICEF interventions are aiming at supporting GoI/MoH priorities: reaching the MDGs 4,5 & 6, while their activities are in line with the GHI principles: Encourage Country Ownership and Invest in Country Led Plans and Increase Impact through Strategic Coordination and Integration. The UNICEF activities support Focus area 1 and 2 and the following IRs:

*Focus Area 1: Catalyze action to accelerate Indonesia's progress toward achievement of MDGs 4,5&6:*MDG 4&5 more specifically the following intermediate results (IR)

IR 1.1: "Improved quality and effectiveness of government and private health systems",

IR 1.2: "District capacity, leadership and health governance improved in a decentralized, district-led system",

IR 1.3: "High impact health interventions effectively implemented at scale in Indonesia".

The evaluation team has observed UNICEF's' actions to improved management of complications, quality of clinical care, referrals, integrated Maternal/Child Health, Malaria in pregnancy and in Malaria prevalence and maternal/neonatal mortality. Although attribution of inputs, investments to outcome is rather difficult to establish in 3 of the 4 MCH/MIP focus districts reporting (since 2 years), the number of maternal deaths and neonatal deaths as a decreasing trend in maternal and/or neonatal mortality, is visible. The PMTCT clinic in Sorong is contributing to the treatment of HIV infected mothers and to the prevention of HIV among children (IR1.1.). All interviewed GoI officials confirmed UNICEF's commitment to stimulate GoI ownership of every intervention (IR1.2.) while especially the Malaria part of the program, despite stock-outs, showed good results and is scaled up at Provincial level (IR1.3.).

Focus Area 2: Enhancing the Use of Quality Research and Evidence in Policy and Programming more specifically:

IR 2.1: "Improved availability of good quality data for programming and policies to improve public health",

IR 2.2: "New technologies and innovations introduced to impact public health outcomes".

Referring to the USAID new Country Development Cooperation Strategy/CDCS (2014-2018), UNICEF interventions in Eastern Indonesia support all development objectives (DO 1 to DO 4) and to the following IRs:

1. IR 1.4**:** Sustainable Development in Targeted Districts in Eastern Indonesia Enhanced. This is especially forSub-Intermediate Result 1.4.2: Basic services enhanced.
2. IR 2.1: Services to reduce preventable deaths particularly among women and children improved.This IR targets the reduction of preventable deaths of women during labor and delivery and of newborns and children under five. In order to achieve this result: (1) the quality of health services must be improved; (2) barriers to access must be lowered.
3. IR 3.1: Control of Infectious Diseases of regional and Global Importance improved.
4. IR 4.2: Evidence-based decision making enhanced.

4.4 Lessons learned

Despite all the challenges faced in Eastern Indonesia, a lot of progress has been made with strong commitment from the local provincial/district government. In most provinces, over half of the Indicators reach 75% or more of their targets Indicators. Health professionals across all levels established to have midwives adopted the Maternity Waiting Home approach. Below are the lessons learned we derived from the evaluation.

1. East Indonesia combines a very poor referral system, an extreme geophysical setting and high transportation costs with a low professional density: of the 1700 OB&GY's, 14 work in Papua and only 9 in Maluku. Also neonatology is limited while anaesthesiology underdeveloped in this part of Indonesia. With the new budget allocation based on Village Law; villages in the remote areas are encouraged to secure some funds to support transportation to refer emergency patients. Further formalizing the referral system at all levels will ensure the roles of each level to stimulate their ownership.
2. The service offered by Comprehensive Emergency Obstetric and Neonatal Care (CEONC) centers: blood bank and 24 hours caesarean section is sub-optimal due to lack of skilled staff. Neonatal Care is often very poor while most Basic Emergency Obstetric and Neonatal Care (BEONC) centers are under-performing due to

recurrent stock-outs of essential drugs and supplies and under-utilized by expecting mothers. This situation results in a low case-load of the midwives: a trained skilled attendant needs to maintain her skills: minimum is 100-200 per year: 8-16 babies per month. As a result a trained attendance is not necessarily a skilled attendant and is no guarantee for a safe delivery / appropriate neonatal care.

3. Lack of quality monitoring/supervision/feedback mechanism results in poor data collection: of the 2013 Papua figures, only 14 of the 29 districts submitted their data to provincial level. None of the districts in Papua and Maluku had a budget for professional monitoring and evaluation and most staff at health center level complained about the lack of supervision. Only when monitoring and supervision are a priority monitoring, evaluation, evidence-based planning and ultimately quality of service can improve.
4. Central fund channelling, a good effort to increase accountability in a decentralized setting, is hampered by the complexities at national level to translate this regulation into administrative practice, while the collaboration through third parties at provincial/district level such as professional organizations/universities/NGOs is challenged by the lack of administrative and programmatic capacity. This situation can only improve through a joined national and regional intervention.
5. Integrating the MIP guidelines and introduced to curriculum of medical/midwifery schools is an excellent way to ensure the continuation transfer of learning/knowledge related to the integration and production of high quality of health service providers. On the job training for health care providers in BEONC has shown good results, however the establishment of a BEONC monitoring system is also crucial to maintain high standard quality of health care services while documenting best practices in facilitating the setting-up and improvement of well-functioning BEONC facilities can contribute, as lessons learned for other areas.
6. Investing in good data management, recording and reporting, will contribute to updating the progress of the program in a timely manner, to avoid logistical issues by reporting stock outs on-time. The SMS-based reporting that was developed in Sorong, adapted from the DHIS, might be a clever way to overcome the geographical and communication issues, and this approach should be simplified, scaled up and replicated to other areas with a similar setting.

7. The integrated MCH/MIP program resulted in "specialization": The CDC / Malaria department is specialized to deal with the policy and the logistics for the integrated program, while the MCH department proved to be effective in operations and monitoring, especially in ensuring the quality of the services provided by health providers.

ANNEX I Scope of Work of the Evaluation

Major Tasks and Duties

The Evaluation team leader will work with the other members of the evaluation team to carry out the SOW listed below. The team leader will be specifically responsible for ensuring evaluation questions are answered, the report is complete, and deliverables are met on time.

Background of the Program to be Evaluated

In support of its 2009-2014 Country Strategy, USAID/Indonesia is funding the 5-year Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia project (2010-2015). Under the 2014-2019 CDCS strategy, USAID/Indonesia will continue to focus on improving basic services including health in Eastern Indonesia, and improving Maternal and Child Health for vulnerable populations across Indonesia.

In October 2010, USAID/Indonesia committed to provide funds through field support to UNICEF/Indonesia under UNICEF Umbrella Grant, Agreement GHA-G-00-07-00007, to continue support for control of Malaria in Pregnancy (MIP) in five provinces in eastern Indonesia. The intent of the program is to reduce malaria-related maternal and child mortality in provinces facing the highest burden of malaria in Indonesia and home to 12 million people. At the same time in 2010, a new maternal and child health (MCH) project was funded with UNICEF under the name ACHIEVE, to accelerate progress in reducing maternal mortality in four of the provinces supported by the MIP program. In 2012 the two separate projects (Malaria in Pregnancy and ACHIEVE) were combined into one project entitled Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia. The integrated MCH and Integrated Malaria Control project retains all major aspects of the two formerly separate projects and is measured by a similar set of indicators. The integration was designed to enhance efficiency and alignment in the joint effort to strengthen government systems for greater coverage and quality of MCH services in Eastern Indonesia.

USAID/Indonesia expects UNICEF, through the Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia project, to conduct the following activities:

4. Sustain effective malaria control to pregnant women and young children in rural Indonesia through synergistic integration of malaria control with antenatal care and immunizations services. Support to improve routine immunization systems by identifying key immunization system challenges and opportunities.
5. Strengthen replication of integrated malaria program coverage among districts through advocacy and leveraging of local Government/GFATM funds and government schemes.
6. Support operational research in Indonesia related to the control of malaria in pregnancy.
7. Enhance management and coordination for policy advocacy and sustainable and effective program outcomes through sharing of experiences and best practices.
8. Provide technical assistance for documentation and advocacy for needful policy and program formulation based on the evidence of current and upcoming initiatives.
9. Provide assistance to improve district based referral system to ensure accessibility of quality emergency care for women and newborns.
10. Ensure that all women and newborns receive comprehensive and quality care during pregnancy, delivery and postnatal periods.

Purpose and Objectives of the Evaluation

The purpose of this performance evaluation is to assess UNICEF's progress towards their stated objectives and indicators in this project, and to make specific recommendations to improve the project's performance. The specific objectives are:

1) To assess the performance of the Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia Project.

2) To make recommendations for the remaining years of the project based on the identified strengths and weaknesses of the program.

3) Make observations and recommendations to that may be used in current efforts or future programming based on lessons learned.

Proposed Evaluation Questions

The core overarching evaluations questions are:

6) What progress has been made towards the project's objectives of improving the quality of Maternal and Child Health and Malaria in Pregnancy programs, and replicating good quality programs broadly? How have UNICEF's inputs and effort contributed to the Government of Indonesia's investments in Maternal and Child Health in Eastern Indonesia, such as the Island Cluster Approach?

7) Is the project appropriately targeted and focused in the breadth of what it does, and how it supports the Government of Indonesia's efforts to improve Maternal and Child Health in Eastern Indonesia?

8) How scalable is the impact of UNICEF's interventions, and how replicable is their approach?

9) Are the project indicators accurately and sufficiently capturing the full scope of the project's impact? Are the indicators sufficiently specified and appropriately designed to measure the project's impact? If not, how can they be improved?

10) How successfully have the management and implementation of the two formerly-separate MIP and ACHIEVE projects been integrated into a single coherent effort, with a unified set of indicators and performance measures? How effectively do the two components achieve synergies and/or leverage each other for greatest impact?

Evaluation Methodology

The evaluation team is expected to develop a methodology which must include document reviews and key informant interviews, and may also include focus groups with stakeholders to assess program effectiveness and outcomes, and appropriate field visits. The team will review documents provided by USAID/Indonesia, including the project SOW, mid-term and annual reports, and other relevant documents. The team should plan to conduct interviews and focus groups with a number of key informant stakeholders including national and local level government staff working at both policy and technical levels, USAID staff, UNICEF project staff, other donors and program staff working in Eastern Indonesia, and project beneficiaries. Suggested partners to interview include, but are not limited to:

- UNICEF staff at both national and local levels
- USAID staff
- Global Fund CCM, Malaria TWG
- Indonesian Ministry of Health
- Dinas Kesehatan Provinsi, including relevant technical section staff
- Dinas Kesehatan Kabupaten, including relevant technical sections staff
- Puskesmas and health facility doctors, nurses, midwives
- Community members
- Relevant staff from BAPPENAS
- Relevant staff from BAPPEDA
- Ministry of Home Affairs

In order to answer the evaluation questions, the team should plan to conduct in-depth site visits in two sites in Maluku, North Maluku, Papua or West Papua in order to: (a) meet with key informants at the local level, (b) explore in detail the impact, opportunities, and constraints of UNICEF's program, and (c) embed the analysis within an accurate understanding of the contexts and capacities that currently exist in Eastern Indonesia. Specific dates and details of site visits will be finalized together with UNICEF.

ANNEX II

Time line and overview of deliverables

No	Time Line	Deliverables	Due Date
1	First week of service	Approved work plan and evaluation team design, including the following: • Summary report of initial findings and approach with draft schedule of field activities (prior to field work) • Draft and final questionnaire(s) to be used during interviews/stakeholder meetings (prior to field work) • Draft Report Outline (prior to field work)	August 15, 2014
2	Second and third week of service	Site visits (Maluku, Papua, and when feasible West Papua) with detailed agenda as follow: • Day 1 → Discussion with UNICEF provincial team • Day 2 →Discussion with District Health Officer and a representative of Provincial Office, and when possible visit and interview relevant District Hospital staff and interview professionals from BAPEDA and other stakeholders. • Day 3 → beneficiaries: community Health Center's staff and clients. Daily team discussion to gather information collected by each member of the team and clarification to UNICEF team when needed.	
3	Fourth week of service	Draft Evaluation report and Oral debrief with USAID, as follows: • Detailed Evaluation Report Outline with bulleted response to evaluation questions	September 5, 2014

		and Draft PowerPoint Briefing (at the end of the synthesis phase) • Finalized PowerPoint De-briefing and initial full report draft (before evaluation team departs Indonesia)	
4	Sixth week of service	Completion and delivery of final evaluation report based on Mission feedback: • Final Evaluation Report following standard reporting format and branding guidelines (within 1 month upon completion of the field works including Mission comments/ recommendations).	September 16, 2014

ANNEX III

Itinerary and Data Collection Schedule and Informants. 08-08 to 09-16-2014

Date	Time	Where	Agenda	Informant(s)
13/8	2.00 PM	UNICEF Office	Discussion with UNICEF National Office Team	Bill Hawley, Ferdinand Laihad, Karina Widowati, Robin Nandy, Peter Leth
14/8	6.30 AM	MoH, Rasuna Said	Interview with MoH	Ibu Erna
	9.00 AM	MoH, Percetakan Negara	Interview with Malaria Programme, MoH	Pak Asik Surya
18/8	8.15 AM	Fly to Ambon	GA 646	
	3.00 PM	Check in	Amaris Hotel, Ambon	
	4.00 PM	PHO Maluku	Interview with Head of PHO	Dr. MeikePontoh
	5.00 PM	PHO, Maluku	FGD with PHO Staff	Natje, Thomas, Ama, Daut, Hans
19/8	7.45 AM	Fly to Saumlaki	Wings Air IW 1514	
	10.00 AM	Bupati Office, Saumlaki MTB	Meet and greet with Bupati	Pak Bitzael S. Temmar
	11.00 AM	Trip to Alusi Kelaan		
	1.00 PM	Alusi Kelaan	FGD with Community Leaders	Head of sub-districts, Head of villages and 14 community leaders
			FGD with Women	2 groups @6 women
	3.00 PM		Visit PONED facility	
	3.30 PM		FGD with HC Staff (5 staff)	Head of Health Center, Staff at MCH, Malaria, Lab Analyst
	4.30 PM	Back to Saumlaki		
	5.30 PM	RSUD PP Magretty, Saumlaki	Visit PONEK facility	
	6.00 PM		FGD with RSUD Staff	Director of Hospital, Dr. Lex , Midwives, Clinic Manager and Anesthesia Nurse
20/8	6.00 AM	Trip to Adaut		
	10.00 AM	Maternity Waiting Home, Adaut	FGD with Cadres	5 cadres
			FGD with Clients	6 clients
	12.00 PM	Village Hall, Adaut	FGD with PKK	
			FGD with Community leaders	Head of sub-districts, Head of villages and community leaders
	1.00 PM	Adaut HC	Visit PONED facility	
	2.00 PM	Trip to Nyafar Nifmas		
	2.30 PM	Nyafar Nifmas	FGD with Community	All villagers
	4.30 PM	Trip Back to Saumlaki		
	7.00 PM	Harapan Indah	FGD with DHO and	Dr. Juliana (Head of

		Hotel	Bappeda Staff	DHO), Bappeda Health Staf, DHO MCH and CDC Staff
21/8	8.00 AM	Bupati Office	De-brief with Bupati of MTB	Bupati and Head of DHO
	9.45 AM	Fly to Ambon	Wings Air IW 1515	
	1.00 PM	UNICEF Office, Ambon	Discussion with UNICEF Staff	Olivi and Hellen
22/8	7.00 AM	Fly to Jayapura	Lion JT 791 and JT894 via Makassar	
	4.30 PM	UNICEF Office, Jayapura	Discussion with UNICEF Staff	Sudhir Kanal, Jana and Ratih
	6.30 PM	UNICEF Office, Jayapura	Discussion with SUM 2 Papua	Novia
23/8	8.00 AM	Trip Depapre HC		
	10.00 AM	Depapre HC	Visit PONED facility	
	10.30 AM		Discussion with PKM Staff	Head of Health Center, Midwives, Nurses and Lab Analyst
	11.30 AM		Visit Maternity Waiting Home	3 midwives in-charge of the house
	12.30 PM	Sentani HC	Discussion with PKM Staff	Head of PKM, Midwives and Malaria staff
	1.30 PM		Visit PONED facility	
	4.00 PM	UP2KP Office	Discussion with Head of PHO Papua	Drg. Aloysius Giyai
	6.30 PM	Hotel	Discussion with KINERJA Papua	Achmad Tamrin
24/8		Hotel	Writing and compiling discussion	
25/8	8.30 AM	PHO Papua	Discussion with PHO Papua staff	Dr. Agnes, Pak Tarman and Pak Kadek
	10.00 AM	Poltekkes Papua	Discussion with Poltekkes Papua staff	Frans Manansang, BerlianaTampubolon, Rai, Robert, Wiwik
	11.30 AM	RSUD Yowari	Discussion with Director and Staff	Erni, Brian, Dr. Yerry and Dr. Frans
	1.30 PM	DHO Jayapura District	Discussion with DHO Jayapura District	Khairul Lie, Pak Jeffrey, Pungut, Kristanti, Eduard Sihotang, Umim, Delila
	4.30 PM	Hotel	Discussion with SUM 1 Papua	Gus Sutakertya
26/8	10.20 AM	Fly to Sorong	GA 471	
	2.00 PM	Hotel	Discussion with UNICEF West Papua	Sudhir Kanal, Nurlely Bethesda

			Staff	
	6.00 PM	Hotel	Discussion with PHO West Papua Staff	Dr. Victor Nugrahaputra
27/8	8.00 AM	Mayamuk HC	Visit and discussion with PKM Staff	Pak Dantje (Head of Health Center), Ibu Anita, Lab Analyst
	10.30 AM	Aimas HC	Visit PONED facility and discussion with PKM Staff	Ibu Yatinah, Dr. Rani, Ibu Paula, Ibu Eka, Ibu Putri, Ibu Grace, Ibu Margaretha
	1.00 PM	DHO Sorong District	Discussion with DHO staff	Dr. Agustinus Luther, Pak Narwan, Pak Kadir, Pak Ning
	6.00 PM	Hotel	De-brief and clarification from PHO	Dr. Victor
28/8	8.00 AM	Malawe HC	Visit demons site	Ibu Sulce, Ibu Vince
	10.00 AM		Interviews with PKM clients	4 Female clients
	11.30 AM	Hotel	Discussion with UNICEF West Papua Staff	Nurlely Bethesda
	2.00 PM	Fly to Jakarta	GA 699 and GA 655 via Makassar	
29/8	8.00 AM	Hotel	Writing and compiling discussion	
1/9	10.00 AM	MoH, Rasuna Said	Discussion with MoH	Pak Lukas Hermawan and Pak Risky
2/9	9.00 AM	UNICEF ffice	Report writing	
3/9	2.00 PM	USAID Office	Debrief preparation presentation	
4/9	10.00 AM		Interview with COP EMAS	Mrs. Anne Hyre

ANNEX IV
LIST OF INFORMANTS

No	Names	Institution	Position
National Level			
1	Erna Mulati, MD, MSc CMFM	MoH	Head of Child Health Subdirectorate
2	Lukas Hermawan, MD, MKes	MoH	Head of pregnant women Subdirectorate
3	Riskiyana Sukandhi Putra, MD, M.Kes	MoH	Head of delivery and post-pregnancy Subdirectorate
4	Asik Surya, MD, MPPM	MoH	Deputy Director for National Malaria Control Program
5	Edhie Rahmat	USAID	HSS Specialist
6	Mildred Pantouw, MPH	USAID	MCH Project Management Specialist
7	Maria J. Pinto	USAID	MCH/Nutrition Specialist
8	Masee Bateman	USAID	Sr. Health Advisor
9	John Rogosch	USAID	Interim Director of Health Office
10	Ratna Suwandono	USAID	USAID Liaison Officer
11	Dr. Robin Nandy, MBBS, MPH	UNICEF	Chief, Child Survival & Development
12	Ferdinand Laihad, MD	UNICEF	Malaria Health Specialist
13	Bill Hawley	UNICEF	Health Specialist
14	Karina Widowati, MD, MPH	UNICEF	Maternal and Newborn Health Specialist
15	Budhi Setiawan, MD, MPH	UNICEF	Health Specialist
16	Peter Leth	UNICEF	Chief of Planning, Monitoring and Evaluation Cluster
17	Anne Hyre	EMAS	Country Director
Provincial Level			
18	Olivi Silalahi, MD	UNICEF Maluku	Malaria and EPI Officer
19	Hellen Parrera	UNICEF Maluku	Operations Assistant
20	Sudhir Kanal, MD	UNICEF Papua	Child Survival and Development Specialist
21	Jana Fitria Kartika Sari, MD, MKes.Trop	UNICEF Papua	Malaria and EPI Officer
22	Ratih Woelandaroe, MD, MSc	UNICEF Papua	MCH Officer
23	Nurlely Bethesda Sinaga, MD, MKM	UNICEF West Papua	MCH Officer
24	Meike Pontoh, MD	PHO Maluku	Head of PHO
25	Hans Tanikwele	PHO Maluku	Immunization
26	Daud Samal	PHO Maluku	Malaria Program

27	Rachma Badiu	PHO Maluku	MCH Staf
28	Thomas Matulessy	GF Maluku	Program Officer
29	Anatje Noya	GF Maluku	PUMK Unicef
30	Drg. Aloysius Giyai	PHO Papua	Head of PHO Papua
31	Drg. Agnes Ang	PHO Papua	Key person for Health Partner Forum of PHO Papua
32	Sutarman, SKM	PHO Papua	Basic Health Services Staff
33	Kadek Hermanta, SKM, M.Si	PHO Papua	Program Staff also as Operational Activities PIC
34	Victor Eka Nugrahaputra, MD, MKes	PHO West Papua	Head of Health Services Division
35	Novia Purnamasari	SUM 2 Papua	Regional Coordinator
36	Achmad Tamrin	KINERJA	Program Manager Papua
37	Ida Bagus Sutakertya	SUM 1 Papua	Team Leader Papua Province, Senior Technical Officer: Prevention
38	Frans Manangsang, SKM, MKes	Poltekkes Papua	Lecturer (Epidemiology, Malaria), Secretary of Midwifery major
39	Berliana Tampubolon, SKM, MKes	Poltekkes Papua	Lecturer (Midwifery Nutrition Academy)
40	I Rai Ngardita, SKM, MKes	Poltekkes Papua	Head of Nutrition Academy
41	Robert	Poltekkes Papua	Head of Nursing Academy
42	Wiwik Mulyaningsih, SKM	Poltekkes Papua	Lecturer (Environmental Health Academy)
District Level			
43	Drs. Bitzael. S. Temmar	Saumlaki	*Bupati*/Head of the District
44	Juliana CH Ratuanak, MD	DHO Saumlaki	Head of DHO Saumlaki
45	Nel Kulalean	DHO Saumlaki	Head of Family Health Division
46	Candra Utukaman	DHO Saumlaki	Head of Disease and Disaster Prevention
47	John Lekatompessy	DHO Saumlaki	PIC for Operational Activities
48	Nusye Batmomolin	Bappeda Saumlaki	Head of Health Division
49	Theo Resilowi, MD, MARS	RSUD PP Magretty, Saumlaki	Director
50	Lexy Ruitan, MD, MARS	RSUD PP Magretty, Saumlaki	Doctor Plus
51	Khairul Lie, SKM	DHO Jayapura District	Head of DHO Jayapura district
52	Ir. Jeffrey Koloay	Bappeda Kab. Jayapura	Head of Social and Cultural Division
53	Pungut Sunarto, SKM	DHO Jayapura district	Head of Communicable Disease and Control Division

54	Kristanti, SKM	DHO Jayapura district	Head of Prevention and Control Subdivision
55	Eduard Sihotang, Apt	DHO Jayapura district	PIC for Operational Activities, Head of Program Planning
56	Usmiati, SKM	DHO Jayapura district	Staff for General Affairs
57	Delila Meheu	DHO Jayapura district	Head of MCH Subdivision
58	Nurhayati	DHO Jayapura district	Malaria Officer of DHO Jayapura
59	Brian, MD	RSUD Yowari, Jayapura	Pediatrician Assistant
60	Erni	RSUD Yowari, Jayapura	Nurse, PIC Perinatology
61	Frans Sigala, MD, Sp.Rad	RSUD Yowari, Jayapura	Director
62	Yerry, MD	RSUD Yowari, Jayapura	Director of Medical Services
63	Agustinus Luther, MD	DHO Sorong	(Temp) Head of DHO
64	Sunarwan Avrilia, MPH	DHO Sorong	Health Services Division Staff
65	Kadir	DHO Sorong	GF Representative for Malaria program,
66	Ning Santjojo	DHO Sorong	Head of Family Health Division
67	Sulce Siwabessy	DHO Sorong Municipality	Head of Family Health Division
Community Level			
68	TH Lakafin, Amk	Saumlaki	Head of CHC Alusi Kelaan
69	Sarce Meren	Saumlaki	Imunization Staff CHC Alusi Kelaan
70	M.C. Warmanuk	Saumlaki	Malaria Staff Alusi Kelaan
71	Hafni Nanavidin	Saumlaki	Education Staff Selaru
72	I. Zakarias Lessy	Saumlaki	Head of Subdistrict Selaru
73	Adam Sainyalit	Saumlaki	Secretary of Subdistrict Selaru
74	Ari Melalolim	Saumlaki	Religious Leader Selaru
75	Heri Lerobulan	Saumlaki	Community Leader Selaru
76	Bernard Amarduan	Saumlaki	Head of Sub-subdistrict Wera
77	David Hutabarat, S.Pd	Saumlaki	*Syahbandar*
78	Semy Rotngoran	Saumlaki	Community leader
79	Ika Bailayar	Saumlaki	Head of Sub-subdistrict Adaut
80	Ladewik Nuan	Saumlaki	Secretary of Sub-subdistrict Adaut
81	Meky Baumase	Saumlaki	Head of Sub-subdistrict Lingat
82	Daniel, MD	Jayapura	Head of CHC Depapre
83	Vera	Jayapura	Lab Analyst CHC Depapre
84	Hilda	Jayapura	MCH and Family Planning Staff CHC Depapre

85	Oktovina	Jayapura	Malaria and EPI Staff CHC Depapre
86	Lea	Jayapura	MCH and IMCI Staff CHC Depapre
87	Dian Gritnowati, MD	Jayapura	Head of CHC Sentani
88	Dantje	Sorong district	Head of CHC Mayamuk
89	Anita	Sorong district	Midwives Coordinator CHC Mayamuk
90	Yatinah	Sorong district	Midwife CHC Aimas
91	Rani, MD	Sorong district	Doctor Plus, GP CHC Aimas
92	Paula	Sorong district	Nurse CHC Aimas
93	Eka	Sorong district	Midwife CHC Aimas
94	Putri	Sorong district	Midwife CHC Aimas
95	Grace	Sorong district	Midwife CHC Aimas
96	Margaretha	Sorong district	Midwife CHC Aimas
97	Vince Bakker, SKM, MM	Sorong Municipality	Head of CHC Malawe

ANNEX V

Task division of the Evaluation Team

The three professionals worked as a team, interviews and discussion with UNICEF, USAID staff and with stakeholders and authorities in the field were held as team discussions. For efficiency reasons the team sometimes divided specific evaluation tasks when needed while team members also kept their specific task division.

Lucas Pinxten, team leader is responsible for general evaluation methodology, professional health system, MCH/IMC input, coordination, implementation, quality assurance, and reporting and contract matters. Besides keeping track of the general evaluation process and keeping the time frame he will specifically focus on the evaluation of the progress against indicators at UNICEF office level, lessons learned and strategic choices of all stakeholders and on the contributions of the Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia Program to the strengthening of the Indonesian health system.

Siti Nurul Qomariyah, evaluation specialist, will guide the team in the approach of MoH and stakeholders in the MCH/IMC field, she is also responsible for the specific evaluation methodology: matching qualitative and quantitative methods to evaluation topics, developing and executing qualitative and quantitative evaluation instruments to assess UNICEF methods and progress against indicators at district level. Besides the quality assuring of the methodology of this evaluation she will specifically focus on the district level contributions of the Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia Program to the strengthening of the health system.

Irma Anintya Tasya, Public health project management and HIV (PMTCT) / MCH specialist will be responsible for translation, administrative and logistical aspects. She will help the team to execute a well-coordinated and well-implemented evaluation, pick up loose ends and will specifically focus on provincial level contributions of the Maternal and Child Health and Integrated Malaria Control in Eastern Indonesia Program to the strengthening of the health system.

ANNEX VI

Overview structural Interview

	Questions	Methods	Informants
1	What progress has been made towards the project's objectives and against indicators of improving the quality of Maternal and Child Health and Malaria in Pregnancy programs, and document learning agenda for effective replication of good quality programs How do you document and attribute this?	- Presentation by UNICEF provincial team - Discussion of the progress reported against the list of MCH/IMC indicators - FGDs - Observations to PKM and below	- UNICEF Provincial team - UNICEF JAKARTA - Beneficiaries in supported districts
2	How have UNICEF's inputs and efforts contributed to the Government of Indonesia's investments in Maternal and Child Health in Eastern Indonesia, such as the Island Cluster Approach? a. National: how many research projects do you support? Is there a research agenda, who sets the research priorities and who coordinates this agenda. How do these results translate into implementation? b. How do you document results/best practises? c. How do you share your research results? d. How do you share good practises/lessons learned and on what level? e. How does this positive deviance approach influence the decision makers at district provincial level? f. Who initiated the Island Cluster approach and what is the UNICEF support? g. How do they learn the positive deviance? h. What are the moments for using structural approach? Routine meetings? Consensus and strategic meeting? How often do you have meetings? What are the results of the meetings?	- UNICEF team presentation/case study to illustrate success by outcome indicators - FGDs - In-depth interview	- UNICEF Provincial team - Counterparts at district and provincial - UNICEF Jakarta

	i. Can you give an example of some of the decisions based on this kind of meetings?		
3	Is the project appropriately targeted and focused in the breadth of what it does?	- FGDs - In-depth interview	- UNICEF Provincial team - Counterparts at district and provincial - UNICEF Jakarta - MoH (Malaria, MCH)
	Are the performance indicators coherent with the intended activities?		
	a. Logical/results framework? b. Assumptions/requirements? c. Per each objective, what are the indicators? d. How far are you with the deliverables? e. How do you deal with unexpected set-backs?		
	Are the project activities consistent with the National and Local MCH/IMC control priorities?		
	How do you sustain Malaria control to pregnant women and young children?		
	Are the project indicators accurately and sufficiently capturing the full scope of the project's impact?		
	Are the indicators sufficiently specified and appropriately designed to measure the project's impact? If not, how can they be improved?		
	How does the MCH/IMC project supports the Government of Indonesia's efforts to improve Maternal and Child Health in Eastern Indonesia?		
	How does the project realize the integration of Malaria control with ANC and immunizations services?		
	How does the project support/improve routine immunization system?		
4	How is the coordination and harmonization of the implementation with other USAID and non-USAID funded activities? Other networks?	- FGDs - In-depth interview	- UNICEF Provincial team - Counterparts at district and provincial level - UNICEF Jakarta - MoH (Malaria, MCH)
	How is the training used for the official resources/professional association?		
	How do you improve the district based referral system?		
	How do you involve public and private health providers?		
5	How scalable is the impact of UNICEF's	- FGDs	- UNICEF

	interventions, and how replicable is their approach? Would counterparts take this approach on board using their own funds?	- In-depth interview	Provincial team - Counterparts at district and provincial level - UNICEF Jakarta - MoH (Malaria, MCH)
6	How successfully have the management and implementation of the two formerly-separate MIP and ACHIEVE projects been integrated into a single coherent effort, with a unified set of indicators and performance measures?	- FGDs - In-depth interview	- UNICEF Provincial team - Counterparts at district and provincial level - UNICEF Jakarta - MoH (Malaria, MCH)
	How effectively do the two components achieve synergies and/or leverage each other for greatest impact?		
7	How does the project adapt to changes of GoI policies in implementing external assistance (e.g. fund channelling mechanisms, etc)?	- FGDs - In-depth interview	- UNICEF Provincial team - Counterparts at district and provincial level - UNICEF Jakarta - MoH (Malaria, MCH)

ANNEX VII
Interview guidelines, MoH, UNICEF Country Office, DHO/PHO, UNICEF Provincial Offices and clients.

Interview guideline MoH

	Questions
1	How have UNICEF's inputs and efforts contributed to the Government of Indonesia's investments in Maternal and Child Health in Eastern Indonesia, such as the Island Cluster Approach?
	a. How do they document results/best practises? b. How do they share their research results? c. How do they share good practises/lessons learned and on what level? d. How does positive deviance approach influence the decision makers at e. National and/or provincial and/or district level? f. Who initiated the Island Cluster approach and what is the UNICEF support?
2	Is the project appropriately targeted and focused in the breadth of what it does?
	Are the project activities consistent with the National and Local MCH/Malaria control priorities?
	What are the efforts to sustain Malaria control to pregnant women and young children?
	Are the indicators sufficiently specified and appropriately designed to measure the project's impact? If not, how can they be improved?
	How does the MCH/IMC project support the Government of Indonesia's efforts to improve Maternal and Child Health in Eastern Indonesia?
	How does the project realize the integration of Malaria control with ANC and immunizations services?
	How does the project support/improve routine immunization system?
3	How is the coordination and harmonization of the implementation with other USAID and non-USAID funded activities? Other networks?
	How do they improve the district based referral system?
	How do they involve public and private health providers?
	How often do you have meetings? What are the results of the meetings? Can you give an example of some of decision based on meetings?
4	How scalable is the impact of UNICEF's interventions, and how replicable is their approach?
	Would you take this approach on board using your own funds?
5	How successfully have the management and implementation of the two formerly-separate MIP and ACHIEVE projects been integrated into a single coherent effort, with a unified set of indicators and performance measures?
	How effectively do the two components achieve synergies and/or leverage each other for greatest impact?
6	How does the project adapt to changes of GoI policies in implementing external assistance (e.g. fund channelling mechanism etc)?

Interview guideline UNICEF Country Office

	Questions
1	What progress has been made towards the project's objectives of improving the quality of Maternal and Child Health and Malaria in Pregnancy programs, and document learning agenda for effective replication of good quality programs?
	How do you document and attribute this?
2	How have UNICEF's inputs and efforts contributed to the Government of Indonesia's investments in Maternal and Child Health in Eastern Indonesia, such as the Island Cluster Approach?
	g. National: how many research projects do you support? Is there a research agenda, who sets the research priorities and who coordinates this agenda? h. How do these results translate into implementation? i. How do you document results/best practises? j. How do you share your research results? k. How do you share good practises/lessons learned and on what level? l. How does this positive deviance approach influences the decision makers at District and/or provincial level? m. Who initiated the Island Cluster approach and what is UNICEF's support? n. How do they learn the positive deviance? o. What are the moments for using structural approach? Routine meetings? Consensus and strategic meetings? How often do you have meetings? What are the results of the meetings? p. Can you give an example of some of decision making based on this kind of meetings?
	Is the project appropriately targeted and focused in the breadth of what it does?
	Are the performance indicators coherent with the intended activities?
	1. Logical/results framework? 2. Assumptions/requirements? 3. Per each objective, what are the indicators? 4. How far are you with the deliverables? 5. How do you deal with unexpected set-backs?
	Are the project activities consistent with the National and Local MCH/Malaria control priorities?
	How do you sustain Malaria control to pregnant women and young children?
	Are the project indicators accurately and sufficiently capturing the full scope of the project's impact?
	Are the indicators sufficiently specified and appropriately designed to measure the project's impact? If not, how can they be improved?
	How does the MCH/IMC project support the Government of Indonesia's efforts to improve Maternal and Child Health in Eastern Indonesia?
	How does the project realize the integration of Malaria control with ANC and immunizations services?
	How does the project support/improve the routine immunization system?
4	How is the coordination and harmonization of the implementation with other USAID and non-USAID funded activities? Other networks?
	How is the training used by the official resources / professional association?
	How do you improve the district based referral system?

	How do you involve public and private health providers?
5	How scalable is the impact of UNICEF's interventions, and how replicable is their approach? Would counterparts take this approach on board using their own funds?
6	How successfully have the management and implementation of the two formerly-separate MIP and ACHIEVE projects been integrated into a single coherent effort, with a unified set of indicators and performance measures?
	How effectively do the two components achieve synergies and/or leverage each other for greatest impact?
7	How does the project adapt to changes of GoI policies in implementing external assistance (e.g. fund channelling mechanisms etc)?

Interview guideline for PHO and DHO

	Questions
1	How have UNICEF's inputs and efforts contributed to the Government of Indonesia's investments in Maternal and Child Health in Eastern Indonesia, such as the Island Cluster Approach?
	1. How do they document results/best practises? 2. How do they share their research results? 3. How do they share good practises/lessons learned and on what level? 4. How does positive deviance approach influence the decision makers at district/ provincial level? 5. Who initiated the Island Cluster approach and what is the UNICEF support?
2	Is the project appropriately targeted and focused in the breadth of what it does?
	Are the project activities consistent with the Local MCH/Malaria control priorities?
	What are the efforts to sustain Malaria control to pregnant women and young children?
	Are the indicators sufficiently specified and appropriately designed to measure the project's impact? If not, how can they be improved?
	How does the MCH/IMC project support the Government of Indonesia's efforts to improve Maternal and Child Health in Eastern Indonesia?
	How does the project realise the integration of Malaria control with ANC and immunizations services?
	How does the project support/improve the routine immunization system?
3	How is the coordination and harmonization of the implementation with other USAID and non-USAID funded activities? Other networks?
	How do they improve the district based referral system?
	How do they involve public and private health providers?
	How often do you have meetings? What are the results of the meetings? Can you give an example of some of decisions based on meetings?
4	How scalable is the impact of UNICEF's interventions, and how replicable is their approach? Would you take this approach on board using your own funds?
5	How effectively do the two formerly -separate MIP and ACHIEVE projects achieve synergies and/or leverage each other for greatest impact?

6	How does the project adapt to changes of GoI policies in implementing external assistance (e.g. fund channelling mechanism etc)?

Interview guideline UNICEF Provincial Office

	Questions
1	What progress has been made towards the project's objectives of improving the quality of Maternal and Child Health and Malaria in Pregnancy programs, and document learning agenda for effective replication of good quality programs?
	How do you document and attribute this?
2	How have UNICEF's inputs and efforts contributed to the Government of Indonesia's investments in Maternal and Child Health in Eastern Indonesia, such as the Island Cluster Approach?
	1. How do you document results/best practises? 2. How do you share your research results? 3. How do you share good practises/lessons learned and on what level? 4. How does this positive deviance approach influence the decision makers at district provincial level? 5. Who initiated the Island Cluster approach and what is the UNICEF support? 6. How do they learn the positive deviance? 7. At what moments is the structural approach used? Routine meetings? Consensus and strategic meetings? How often do you have meetings? What are the results of the meetings? 8. Can you give an example of some decision(s) based on this kind of meetings?
3	Is the project appropriately targeted and focused in the breadth of what it does?
	Are the performance indicators coherent with the intended activities?
	1. Logical/results framework? 2. Assumptions/requirements? 3. Per each objective, what are the indicators? 4. How far are you with the deliverables? 5. How do you deal with unexpected set-backs?
	Are the project activities consistent with the National and Local MCH/Malaria control priorities?
	How do you sustain Malaria control to pregnant women and young children?
	Are the project indicators accurately and sufficiently capturing the full scope of the project's impact?
	Are the indicators sufficiently specified and appropriately designed to measure the project's impact? If not, how can they be improved?
	How does the MCH/IMC project supports the Government of Indonesia's efforts to improve Maternal and Child Health in Eastern Indonesia?
	How does the project realise the integration of Malaria control with ANC and immunizations services?
	How does the project support/improve the routine immunization system?
4	How is the coordination and harmonization of the implementation with other

	USAID and non-USAID funded activities? Other networks?
	How is the training used by the official resources / professional associations?
	How do you improve the district based referral system?
	How do you involve public and private health providers?
5	How scalable is the impact of UNICEF's interventions, and how replicable is their approach? Would counterparts take this approach on board using their own funds?
6	How successfully have the management and implementation of the two formerly-separate MIP and ACHIEVE projects been integrated into a single coherent effort, with a unified set of indicators and performance measures?
	How effectively do the two components achieve synergies and/or leverage each other for greatest impact?
7	How does the project adapt to changes of GoI policies in implementing external assistance (e.g. fund channelling mechanism etc)?

Interview Guideline Clients

	Questions
1	What are your experiences in using the health services in this CHC?
2	Do you find any constraints/benefits/barriers in using the health services in this CHC?
3	What do you get when you have ANC in this CHC/midwives? Probing: Malaria? (if they do not mention it) Immunization? Family planning?
4	Have you/other women had any difficulties in referral process, if needed Probing: How is the service quality at each level (village midwives, district hospital)? Transportation? Cost? Administration?
5	Do you have any recommendation or input to improve the service quality?
6	Do you know about the MCH and IMP program?

Annex VIII. Summary of interviews with UNICEF and Ministry of Health staff from national to HC level

Questions	National	Provinces	Districts	Health Center/hospital
1. How have UNICEF's inputs and effort contributed to the Government of Indonesia's investments in Maternal and Child Health in Eastern Indonesia, such as the Island Cluster Approach? a. How do they document results/best practices? b. How do they share their research results? c. How do they share good practices/lessons learned and on what level? d. How does positive deviance approach influence the decision makers at district/ provincial level? e. Who initiated the Island Cluster approach and what is the UNICEF support?	**Erna Muliati, MD, MSc, CMFM (MoH):** •UNICEF acts as catalisator – helping the MOH in implementing existing programs •UNICEF can see the picture more comprehensively •Strengthen the DHO in developing their plan •There has been discussion between the MOH and UNICEF to develop the work plan: what can be done by each party **UNICEF Jakarta:** •Support to MoH to meet MDG's 4,5,6 and to reduce inequity and increasing service access and quality •Support through Nutrition, Wash and Health programs •Support to decentralization •Modeling and leverage •Try-out integrated programming •Working at district and CHC level offers a "field laboratory" •Advocacy sub national and national level •Advise on "double burden" challenges like obesity and non-communicable diseases. •Development and try-out of	**MeikePontoh, MD (Head of PHO Maluku):** •In 2008 UNICEF initiated the cluster islands approach, helping them in formulating what the approach is. •UNICEF also helping the province in formulating the maternity waiting home, facilitating training and increasing the capacity of the staff at DHO and HC in program planning. •Coordination between programs through 'binawilayah'. One staff in PHO is in-charge for an island/a district (need to know everything about the health problem in specific island/district **UNICEF Maluku (Olivi Silalahi, MD Malaria/EPI Officer)** •Health system support though consensus meeting at provincial level •Positive deviance approach through model CHC, •Capacity building through tailored TA and sponsoring workshops •Development and implementation Malaria curriculum for Poltekkes •Development of guidelines integrated management of MCH/ •Documentation and of results / lessons learned is through the standard UNICEF reporting	**MTB (Juliana Ratuanak, MD - Head of DHO):** •UNICEF supports the district in: •Data analysis for program planning •Formulating the integration of MCH/IMC program •Realizing the maternity waiting home •Training of health providers •Right now, there has been peraturan bupati (PERDA) on the cluster island approach to protect the health providers who work at the pusatgugus (at BEONC/PONED + facilities, to do cesarean section etc.) •Awarded for MDGs award 2013 for their cluster islands approach •Replication of program to North Tanimbar and Seira Island Jayapura: •UNICEF facilitated us to train the HC on IMP, to develop SOP for the ANC, on the job training for microscopic analyst (funded by UNICEF) to ensure no clinical approach on Malaria **DHO Sorong:**	**Alusi HC, MTB** **UNICEF** assists the district by providing funding for training for health providers, formulating guidelines and for data review. **LexyRuitan, MD, MARS – RSUD PP Magretti MTB**: •Training for health providers. However, some of the training was conducted in facilities which have 'sophisticated' medical instruments: when the health providers go back to the hospital; they couldn't do anything as the hospital does not have the instruments. •Not enough staff at the hospital: only one nurse for anesthesia, the midwives are not skilllfull for neonates resuscitation. HC must be able to assess risks. •Faced by challenges, such as delays in diagnosis, family decision, high cost of transportation, communication barriers since not all areas have telephone signals.

	the Cluster Island Approach to strengthen MCH/IMC • PLA community Malaria approach is developed implemented and shared across Kabupaten. • Positive Deviance approach to develop model CHC to stimulate BEONC learning across CHC and from "sister hospital" • Development and implementation of innovative approaches like "waiting homes" • Operationalization of minimal service standards • Structural documentation of lessons learned is not happening **Lukas Hermawan, MD, Mkes (Head of Pregnant Women Division - MoH)** • To support the GoI on the implementation of the program in eastern Indonesia, while on the same time GoI implement in Kalimantan & Sulawesi. • To tackle monitoring and fund channeling, maybe it's better to have a Technical Working Group, since it is difficult if the fund is going through them, especially because of the reporting that will affect their own program	system (6-monthly) • Province and district have embraced positive deviance approaches like waiting homes and model HC • UNICEF supports development of BEONC HC but implementation is hampered by HR (intern doctor and fast turn over of the PPT doctor is the weakest link) • Island cluster approach is an old idea revitalized by UNICEF is well accepted and creates health services crossing Kabupaten borders • MCH needs more support it is still suboptimal • Malaria program runs well but is hampered by stock-outs (bed nets and treatment) **Victor Nugrahaputra, MD, Mkes (Head of Health Services Division - PHO West Papua)** • UNICEF inputs: • Funding for some activities (due to limitation in the local budget). However there has been misunderstanding by the legislative à cost shifting • Technical assistances • Many training have been done but it seems that there is no result from the training – need to improve the capacity of the district staff on program monitoring • The performance of focus districts looks different but between focus districts also different, depend on	• UNICEF inputs: SMS gateway • UNICEF suggests us to do more supervision • Training for Aimas HC on BEONC • Workshop to develop referral manual IMP (in some focus HC) • Laboratory test for Malaria – training for all HCs • Constrains: fund channelling	**Daniel MD, DepapreCHC :** • UNICEF strengthens the system, assisting us in data analysis. • Monitoring was done by UNICEF (Dr. Ratih) • Dr.Ratih assisted in realizing the maternity waiting home, facilitated discussions etc. • UNICEF assists us in developing program planning through the IMP (MCH/IMC, slide standards, Malaria and laboratory etc.) Sentani HC: • UNICEF assists us in developing SOPs, micro planning, training for PLA facilitators **Yowari Hospital (Nurse Erni, Brian MD – Pediatrician Assistant)** • UNICEF assists the hospital by facilitating training for the hospital to be referral hospital on neonatal care. • The hospital belongs to the local government; we need UNICEF to help us advocating the government for the

	• UNICEF has assisted based on the local needs, in the field. **Asik Surya, MD, MPPM (Deputy Director for National Malaria Program):** • The program has benefit, either in strengthening services integration, community empowerment, social mobilization, advocacy and initiation of service model such as cluster islands approach	the commitment of the local government • In the future we need to plan in the beginning, what will be the role of each party; this is to improve the sense of belonging of the local government to the program. • Mentoring model fits very well to the situation in West Papua **UNICEF Papua (Sudhir Kanal, MD, CSD Specialist)** • UNICEF supports MoH provincial and district level with: integrated micro planning, guideline development and implementation, community IMC, flying health service, TA and Capacity building advocacy, and leverage of local and international funds • UNICEF bridges PHO-DHO **UNICEF Papua (Ratih Woelandaroe – MCH Officer):** • UNICEF only supports the local government in implementing their programs. The organization structure at the PHO/DHO makes it difficult now to work with. There are conflicting priorities at the Dinkes. Also at national level, especially the fund channeling system. We work now through third party (professional organization, NGOs etc) – this is not easy. We need to do capacity building first for them. • Money is not a problem in Papua, but the problems are human		logistics problems. Although there has been Permenkes (MoH decree) that the hospital is a referral hospital for neonatal care, the local government does not know. • Stock out for Malaria drug, although the health providers have been trained • Need to evaluate the accuracy of the microscopic analysis in doing Malaria examination. **Dantje Head of CHC and Anita Midwives Coordinator (Mayamuk HC, West Papua):** • UNICEF inputs: • Bed nets, training, IMP (using the approach, now we know that we have many problems in coverage etc: "we used it to have discussion with the local government"), SMS gateway: problem in the beginning but it has been fixed (simplified) • Have one maternity waiting home, managed by a midwife, started May 2014 • Problems in logistics: stock out oxytocin; no

		resources, geographical situation and conflicting priorities **PHO Papua (Drg. AloysiusGiya – Head of PHO)** •The increase in MMR and Child mortality are due to: 1) the increase in reporting, and 2) the policy makers do not know how to select priorities and the health providers work without enthusiasm •UNICEF helps in solving those problems. However we still need to discuss if the activities supported by UNICEF are all correctly targeted **PHO staff Papua (Agnes Ang, MD, Tarman, KadekHermanta, SKM, MSi):** •UNICEF helps us developing module for MIP. Planned for module replication •Also facilitating training for hospital staff (by RSCM hospital) on neonatal care – for the hospital to be referral hospital for neonates. •Soon we will be conducting training for community-IMCI facilitators •Constraints: schedule, monitoring after training		MgSO4 **Aimas HC Bidan Coordinator):** •UNICEF inputs: •BEONC training in Makassar (10 days). We can manage hypertension, resuscitation, manual removal of placenta. We refer premature baby as we don't have incubator. What we have is not the same with what we learned in Makassar. •Monitoring by Dr. Beth (UNICEF) •No ambulance at the HC •Stock out: oxytocin, MgSO4 •Problems: laboratory is not for 24 hours. Only one staff •We promoted the BEONC HC (the facility delivery) by disseminating information that delivery at HC is free but not for delivery at home. •We never perform vacuum delivery because we are afraid if there is emergency situation for the baby •No AMP.
2. Is the project appropriately targeted and focused in the breadth of what it does?	**Erna Muliati, MD, MSc, CMFM (MoH):** •Targets should differentiate between provinces	**UNICEF Maluku (Olivi Silalahi, MD Malaria/EPI Officer**) •Malaria program is well focused (vertical program) and reaches,	**Jayapura (Dinkes)** •**Stock out is caused by** the new e-catalogue system. It	**Adaut HC Bidan Coordinator):** •Estimated pregnant

	• There should be more about indicators of progress (output) and sustainability (commitment) not impact indicators. • To sustain the program development, partners (including UNICEF) should have exit strategy (the step by step process) – this has not been considered. **UNICEF Jakarta:** • Results framework and indicators as agreed upon with donor • Project is in-sync with MoH • Stimulates/advocates development and implementation of guidelines and to influence policy. • Setting professional standards through development of models in selected districts to share best practices	despite the stock outs, its targets (90% of the pregnant women receive screening and a bed net) • MCH (horizontal program) is far more complex and broad: some targets are met • Targets are set at the beginning of the program and we have to work with them • Some targets like introduction of Malaria curriculum in Poltekkes were easy to reach, increased assisted deliveries are difficult to reach • In general indicators cover what we do but some objectives and targets are not well covered by indicators, while we also have activities that have no indicators at all • For Malaria we need an output indicator: reduction of Annual Prevalence Index (API) per village **UNICEF Papua (Sudhir Kanal, MD, CSD Specialist)** • Integrated micro planning is sustainable and system oriented. A good start at HC level but also DHO and PHO level needs more support on MONEV • Flying health services developed to address inequity but financing has to come from APBD • MoH needs health system strengthening especially MONEV last year only 14 of the 29 district submitted reports • Support to curriculum	should not be a problem if HCs report appropriately	women per year: 91 only. (Clarified by the DHO – there is misunderstanding by the HC on their area of coverage. They should also cover the other three villages – because Adaut HC is the referral facility for the cluster island approach). With this coverage, the number of delivery is more than 300. • The HC was used for caesarean section, but the doctor who was trained has left for specialization

		development. Poltekkes is well targeted but we get too many midwives (annual output Jayapura only about 6-700) • Model HC and micro planning are "soft Power" approaches to improve the health system		

3. How is the coordination and harmonization of the implementation with other USAID and non-USAID funded activities? Other networks?	**Erna Muliati, MD, MSc, CMFM (MoH):** •Donor meeting at national level to discuss the focus sites •UNICEF Jakarta: •This is a challenge, seems to be necessary but does rarely happen •With other programs/donors even worse.	**UNICEF Maluku (Olivi Silalahi, MD Malaria/EPI Officer)** •Coordination and harmonization through regular donor meetings at national level •Never happens at provincial level UNICEF Papua (Sudhir Kanal, MD, CSD Specialist) •We coordinate our work on a three-monthly base in the provincial health forum: KNCV, FJI, CHAI, •KINERJA Papua •Collaborates in one of the activities in PKM, where the UNICEF are working with health staff, Kinerja tries to gather information on quality of health services and gives the input to PKM and UNICEF PHO Papua (Drg. Aloysius Giya) •We formed the health partnership forum on June 1, 2014 Victor Nugrahaputra, MD, Mkes (Head of Health Services Division - PHO West Papua) •Development partner forum has been formed, waiting for the governor signature. Need to increase the dialogue (time constrains)		
a. How they improve district based referral system? b. How often do you have meeting? What are the results of the meeting?	**UNICEF Jakarta:** •SMS referral system in West Papua •Desa Siaga is a good approach but very few people in East Indonesia have ever heard of	**UNICEF Maluku (Olivi Silalahi, MD Malaria/EPI Officer)** •Waiting homes is a great success •SMS referral system that is now tried out in West Papua would fit well in Maluku.		•

Can you give an example of some of decision based on meetings? c. How do they involve public and private health providers?	it. • Private sector is under developed	• There are very few private health providers **UNICEF Papua (Sudhir Kanal, MD, CSD Specialist)** • Micro planning, SMS referral system, flying doctors system to support referral from remote areas, and support to establishment BEONC. • Monthly coordination meetings in health forum meeting and incidental meetings with professional organizations like IBI, IDAI and POGI PHO • We have often discussed HR shortages and quick rotation (5 PHO in 2 years in Jayapura!) • The proliferation of new districts (14 in 2012 and 40 in 2014) is hampering the health services: health staff are used for admin tasks • With adding new districts we have no denominator to measure progress against indicators we now have started with "real time" monitoring		
4. How scalable is the impact of UNICEF's interventions, and how replicable is their approach? Would you take this approach on board using your own funds?	**UNICEF Jakarta** • Yes it is replicable, but it takes time and a lot of advocacy; Kabupaten and PHO are fast to take advise and approaches from UNICEF **Asik Surya, MD, MPPM (Deputy Director for National Malaria Program):**	**Meike Pontoh, MD (Head of PHO Maluku)** • The cluster island approach has been taken by the province government (put in the RPJMD) and also by the central government. The government of Maluku now needs to launch regulation on the cluster island approach	**MTB:** • The approach has been replicated and self-funded to other areas, such as North Tanimbar, Seira Island. **Jayapura** • For HIV test and RDT the funding mostly is from GF. It will be a challenge if there is	**Depapre and Mayamuk**: • Maternity waiting home: no funding yet, and it is the midwives who take care of the house

	• The national government has allocated fund for bed net for all population in endemic areas (as much as 24 billion) – not only for MCH targets.. • Encourage local funds allocations for Malaria routine bed nets	• Before there were only 19 *pusatgugus* (the center for each cluster), but now in Maluku, there are 39 *pusatgugus* • To sustain the program, assistance is still needed especially for non-focus districts. UNICEF should not leave until the local government is ready to continue the program. **UNICEF Maluku (Olivi Silalahi, MD Malaria/EPI Officer** • Waiting homes and Malaria program are already scaled up beyond focus districts with APBP money **UNICEF Papua (Sudhir Kanal, MD, CSD Specialist)** • Waiting homes, micro planning, model HC and Malaria screening and treatment in pregnancy are in the process to be scaled up through using local ABPD funds. • MCH is more complex: quality is still not good and midwives have a low caseload to maintain their skills. • PHO Papua (Dr. Aloysius) • There have been many Governor regulations and Provincial regulations related with health issues. They include regulations related to health insurance, and referral system. Proportion for health programs from APBD at districts mostly still below 10%. Only one which is 8% • PHO staff Papua	no support from the district/province government	

		• We still need guidance from UNICEF for the IMP approach, also to review if it can be replicated to other districts. This is also the case for the community-IMCI **Victor Nugrahaputra, MD, Mkes (Head of Health Services Division - PHO West Papua)** • The commitment of the local governments for replication varies – also for funding of some activities (e.g the previous radio medical program) • MIP might be sustainable. In terms of training, but logistics might be a problem in the future.		
5. How effectively do the two formerly -separate MIP and ACHIEVE projects achieve synergies and/or leverage each other for greatest impact?	**UNICEF Jakarta** • The lower in the system the easier it is. PD2 staffs are working very well together. That is not completely the case at Jakarta DG level. It works very well at MoH • The integration with Malaria makes the pregnant women class more popular • Vertical Malaria program works like a wedge in the horizontal MCH program • The challenge is to provide bed nets on time, the droppings are at irregular times. The quality of in-country bed nets are not as good as the GF has.	**PHO Maluku** • Buru, Tual, East Seram are now provide with their own bed nets and RDT • Guide book for midwives and cadres on MiP integration, distributed not only in focus district but in all districts **UNICEF Maluku (Olivi Silalahi, MD Malaria/EPI Officer) and UNICEF Papua (Sudhir Kanal, MD, CSD Specialist)** • After development, implementation of the integrated guidelines and integration in Poltekkes curriculum. Midwives and nurses running the ANC have adopted the integrated Malaria approach: screening and treatment is now part of the ANC package	**MTB:** • The approach has been replicated and self-funded to other areas, such as North Tanimbar, Seira Island.	

		• The integration is good, increased partnership among stakeholders and among related sectors.		
6. How does the project adapt to changes of GoI policies in implementing external assistance (e.g. fund channelling mechanism etc)	**UNICEF Jakarta** • MOH: this has been a challenge for the collaboration work as the MOH does not have enough staff to look after the project administration • We adapt well now we are using village funds to scale up PLA **Lukas Hermawan, MD, Mkes (Head of Pregnant Women Division - MoH)** • We have not yet figured out how to deal with the fund channelling mechanism, maybe establish a technical working group to monitor and to get approval for activities conducted in the field. But this needs to be negotiated and approved with the GoI	**UNICEF Maluku (Olivi Silalahi, MD Malaria/EPI Officer** • UNICEF is flexible in its approach and we are close to our partners. However the current funding channel is problematic **UNICEF Papua (Sudhir Kanal, MD, CSD Specialist and Ratih Woelandaroe, MD – MCH Specialist)** • We stay very close to MoH and together with MOH we see that Maternal mortality is not improving fast enough (only 24% of the indigenous women in the lowest health quintile has assisted birth attendance) while U-5 mortality among indigenous families is 4 times higher compared to non indigenousness ones (110 vs.24 per 1000). • Now we are pushing for more attention for U-5: Integrated community child care does not exists, and virtual no U-5 receives Malaria treatment or sleeps under a bed net • U-five mortality rate doubled since 2012 in both West Papua and Papua • Budget sharing between UNICEF and PHO, discuss which program can be supported, things needed from the health office and from program itself.	**DHO Sorong district:** • The SMS-gateway for reporting has sped up the reporting process. Assessment is needed to see implementation to other program.	

ANNEX IX. Summary of interviews with people at community level

Questions	Women	Kaders - TBA	Community leaders
1. What are your experiences in using the health services in this CHC	Five women (pregnant, post partum) and five women experiencing Malaria in Alusi village, MTB: Sorong: referred by the midwives to go to Malawe HC. 2nd child. Was tested for 10T with counseling	- The services are good, despite there are some limitations in medication	All good, the services are all good In Alusi, they have started communal funds to build latrines in villages, initiated and partly funded by DHO
2. Do you find any constraints/benefits/barriers in using the health services in this CHC	Sorong: - Waiting time for lab is long - Discussed with midwives where they want to deliver the baby, since the PKM doesn't have overnight beds	Adaut + Increased knowledge on pregnancy and baby care + able to help other villagers to maintain their health - Low incentives for cadres (10.000/month) while they need to reach all pregnant women and mothers in the whole village - No permanent place for Posyandu, usually at villager's front yard	Alusi: + FP has lifted their burden as head of the family by limiting the number of births - Limited medication - Hard to find clean water Adaut: + there is clean water in households (80%) + not difficult to refer
3. What do you get when you have ANC in this CHC/ midwives? Probing: • Malaria • immunization • family planning	Adaut - Pregnant/post partum: blood test, bed net, MCH book (but many of them did not get it), free of charge but some only knew that it is free when they were already at HC, No FP method yet. - Women with Malaria: Blood test, medication then blood test again. Pregnant women (Malawe HC, Kota Sorong) Blood test etc (2 women does not know what for? Two women said – 'I don't know,' two women replied to check if I have Malaria, HIV etc.)		- Limited bed nets, since it was only given for pregnant women or children, not for the whole population.
4. Have you/other women had any difficulties in referral process, if needed. Probing: - how are the service quality in each level (village midwives,	Sorong: No, the referral is good, there are no difficulties	Reasons of some women who don't want to deliver at health facilities: Their husband does not agree Cost constraint Transportation challenges (High-	Women group in Adaut: Problem - transportation, logistics at the HC - Transportation to referral center is difficult, especially when the tide is

district hospital)? Transportation? Cost?		tide/waves during rainy season)	high.
5. Do you have any recommendation or input to improve the service quality?	• Providing milk for all pregnant women • All health providers should be nice • Sometimes there was no bed net for the pregnant women, this should be solved • Facility for referral • Electricity • Drugs and instruments for the midwives		Puslinglaut'(PuskemasKelilingLaut/sea mobile CHC) to tackle transportation issue.
6. Do you know about the MCH and IMP program?	yes	yes	yes

Annex X Overview Progress on Program Indicators: Baseline 2010-Results 2013

Progress on program indicators 2010 baseline - 2013 results

Indicators	Indicator number/program	Maluku Utara			Maluku			Papua			West Papua			NTT		
		Baseline 2010	Result 2013	% Reached	Baseline 2010	Result 2013	% Reached	Baseline 2010	Result 2013	% Reached	Baseline 2010	Result 2013	% Reached	Baseline 2010	Result 2013	% Reached
Number of midwifery academy with pre-service training module for bidans developed and implemented (Prov)	1. MIP	1	2	200%	2	3	150%	1	3	300%	3	3	100%	2	2	100%
Number of health centers in focus districts conducting quarterly midwife peer review meeting	2. MIP & MCH	4	9	225%	2	6	300%	10	26	260%	19	30	158%	1	8	800%
Number of districts with standard localized model HC for internship for new staff	3. MIP & MCH	1	2	200%	2	2	100%	1	1	100%	1	1	100%	1	2	200%
Number of health centers in focus district using mother card integrated with malaria for program monitoring	4. MIP & MCH	12	43	358%	2	2	100%	17	31	182%	15	50	333%	28	39	139%
Number of puskesmas reporting no stock outs of essential items for the integrated malaria program (ACTs, RDTs, LLINs) or maternal health program (magnesium sulphate, oxytocin, intravenous antibiotics). (MIP and MCH) Note: MCH data only from puskesmas in focus district	5. ACT/MIP	53	115	217%	65	113	174%	129	279	216%	65	104	160%	200	266	133%
	6. RDT/MIP	53	107	202%	3	90	3000%	129	214	166%	65	83	128%	200	266	133%
	7. LLIN/MIP	53	95	179%	140	120	86%	129	300	233%	65	104	160%	200	NA	
	8. MgSO4/MCH		NA			NA			NA			NA			NA	
	9.Oxytoxine/MCH		NA			NA			NA			NA			NA	
	10. Ampicilin iv/MCH		NA			NA			NA			NA			NA	
Number of districts with effective malaria slide cross checking systems	11. MIP	1	2	200%	1	3	300%	12	3	25%	9	4	44%	21	10	48%
Proportion of pregnant women attending first ANC contact who receive screening and appropriate treatment	12. MIP	8.970	7.500	84%	21.976	11.485	52%	30.426	17.543	58%	28.986	8.593	30%	94.454	67.564	72%
	13. MCH	8.970	7.500	84%	14.416	7.494	52%	NA	NA		12.492	7.093	57%	94.454	67.564	72%
Proportion of pregnant women who attend ANC at least once during their pregnancy	14. MIP	23.046	15.090	65%	29.148	11.485	39%	22.538	17.558	78%	16.004	18.612	116%	NA	85.145	
	15. MCH	21.999	55.600	253%	35.029	18.795	54%	22.538	17.558	78%	NA	NA		113.344	85.145	75%
Proportion of pregnant women attending first ANC contact who receive an insecticide treated bed net	16. MIP	8.970	6.234	69%	36.901	13.069	35%	16.840	16.665	99%	10.925	12.542	115%	NA	1.295	
	17. MCH	8.970	6.234	69%	24.000	NA		NA	NA		12.492	1.099	9%	62.969	1.295	2%
Number of districts with budget allocation for integrated MCH program that is at least equal to the total contribution of the GFATM and UNICEF	18. MIP&MCH	1	6	600%	1	0	0%	2	4	200%	2	0	0%	1	NA	
Proportion of pregnant women attending four antenatal visit during their pregnancy	19. MCH	77%	48%	63%	73%	37%	50%	21%	32%	154%	48%	50%	104%	66%	68%	103%
Proportion of delivery assisted by skilled birth attendance	20. MCH	69%	51%	74%	70%	37%	53%	25%	46,0%	184%	66%	68%	102%	76%	81%	107%
Proportion of newborns and mothers who received a check up by skilled health provider within 2 days of delivery (KF1 & KN1)	21. MCH/KF1	66%	53%	80%	71%	38%	53%	19%	29,5%	155%	49%	0,67	136%	71%	71%	100%
	22. MCH/KN1	70%	52%	74%	73%	45%	62%	21%	39,0%	186%	50%	0,68	136%	82%	75%	92%

Change in maternal & neonatal deaths 2012 - 2013		2012 result	2013 result	% change	2012 result	2013 result	% change	2012 result	2013 result	% change	2012 result	2013 result	% change	2012 result	2013 result	% change
Number maternal death from direct and indirect cause	# maternal death	42	38	-10%	69	31	-55%	65	89	37%	47	57	21%	172	NA	
Number of death during the first 28 completed days of life in a year	# neonatal death	109	187	72%	231	89	-61%	172	133	-23%	97	157	62%	977	NA	

Progress summary: Indicators reached	Maluku Utara	Maluku	Papua	West Papua	NTT
>/= 100% of target reached	10	7	12	13	9
75-100%	3	1	3	1	2
50-75%	6	7	1	0	3
</=50%	0	3	1	4	1
Undetermined	3	4	5	4	7

Cave Indicators 12-17 baseline and reports are in numbers
Maluku Utara: indicator 2: no baseline 2010 but target 2012
Maluku: indicator 2,4,11,18: targes 2011
Papua: indicator 14,15: no baseline 2010 but targets 2012
West Papua: indicator 13,15,17: no baseline 2010 but targets2011
Nusa Tengara Timur: indicators 19,20,22 baseline 2010 all other indicators: targets 2011

Annex XI Recommendations and Priority Matrix

Priority	Recommendations	Action by				
		MOH		UNICEF	USAID	
		Nat	PHO	DHO		
For the remaining years						
1	UNICEF advocates for a buffer stock at DHO-PHO level for Oxytocin, Magnesium sulphate, RDT and ACT and ILLNs, and increases its efforts to strengthening the referral system and the quality of BEONC sites		√	√	√	
2	To use the synergy obtained by the integrated program to inform expecting mothers of the benefits of the JKN health insurance scheme, and to promote skilled delivery at an official BEONC site				√	
3	To put strong output indicators for leverage, such as ensuring sustainable funding from the local government to support the program				√	√
4	To improve the current routine data collection system and development of specific indicators to measure the results of the integrated of MCH/MIP program		√	√	√	
5	To reduce the intake of student at the midwifery school and the intake of new midwives through a "numerous clausus" system, to re-certify midwives having a caseload lower than 100 deliveries per year and to promote "4 hands delivery"	√ (with IBI)				
6	UNICEF to strengthen its evidence-based health programming and documentation by increasing operations research (plus budget), systematic documentation and sharing				√	

	of qualitative and quantitative results on the contextual conditions and the effect of intervention programs.					
7	UNICEF to support the GoI in selecting appropriate quality of care indicators and finding the mechanism to measure them	√	√	√	√	
8	refresher and new training of health professionals to counter staff rotations and to improved facilitative supervision by MoH staff to maintain these skills and ensure quality of services				√	
9	To add outcome indicators, based on agreed national indicators for both malaria and MCH	√			√	√
10	To add output indicator for integrated MCH/MIP i.e.: proportion of villages reducing their endemicity level' and number/percent of pregnant women with presumed/confirmed and treated malaria	√			√	√
11	Follow up the progress of MWH try out in Banten Province				√	
12	To align Kinerja and UNICEF specific activities					√
For future programming						
1	UNICEF to have a stronger focus on strengthening the basic integrated maternal/neonatal health services including safe deliver practices and neonatal resuscitation at Health Center / BEONC level instead of trying to cover the whole spectrum of Maternal and Neonatal health				√	
2	To strengthen the monitoring and evaluation with a combination of integrated planning and facilitative supervision to improve quality of care and to guide program planning	√	√	√	√	

Annex XII

Table 2. Global core indicators for assessing the quality of health care provided to mothers, newborns and children in health facilities

Core indicator	Numerator	Denominator	Data source	Methods
Mothers				
Proportion of antenatal care visits at which blood pressure was measured	No. of antenatal care visits at which blood pressure was measured	Total no. of antenatal care visits	Antenatal care registry or hand-held prenatal record (facility-specific)	Collected by delegated staff from available records
Proportion of women with severe preeclampsia or eclampsia treated with magnesium sulfate injection	No. of women with severe preeclampsia[a] or eclampsia[b] treated with magnesium sulfate injection	Total no. of women with severe preeclampsia or eclampsia	Birth unit or maternity registry	Collected by delegated staff from available records
Proportion of women receiving oxytocin within 1 min of birth of infant	No. of women receiving oxytocin immediately after birth of the infant and before birth of placenta, irrespective of mode of delivery	Total no. of women giving birth in the health facility	Birth unit registry, patient records	Collected by delegated staff from available records or chart review
Proportion of women with prolonged labour	No. of women who have not given birth or were not transferred out within 12 h of active labour[c]	Total no. of women in active labour in the health facility	Generally available through birth records, partographs	Collected by delegated staff from available records
Intrapartum stillbirth rate	No. of stillborn infants weighing > 1000 g and fetal heart rate documented on admission	Total no. of births of infants weighing > 1000 g in facility	Admission and labour ward registry, partographs	Collected by delegated staff from available records
Proportion of women with severe systemic infection or sepsis in postnatal period, including readmissions	No. of women seen in the facility with severe systemic infection or sepsis in postnatal period,[d] including readmissions after birth in facility	Total no. of women giving birth in the health facility	Admission and discharge records	Collected by delegated staff from available records
Newborns				
Proportion of health facilities with functional bags and masks (two neonatal mask sizes) in the delivery areas of maternity services	No. of health facilities with functional bags and masks (two neonatal mask sizes) in the delivery areas of maternity services	Total no. of health facilities with maternity services assessed	Direct observation (e.g. facility and self-assessment)[e]	Facility surveys, self-assessments

[54]Source: http://www.who.int/maternal_child_adolescent/documents/measuring-care-quality/en/

Core indicator	Numerator	Denominator	Data source	Methods
Newborns				
Proportion of newborns who received all four elements of essential care: • immediate and thorough drying • immediate skin-to-skin contact • delayed cord clamping • initiation of breastfeeding in the first hour	No. of newborns who received all four elements of essential newborn care	Total no. of live births in the health facility	Direct observation, perinatal information system, charts	Case observation, chart reviews, exit interviews of mothers
Proportion of health facilities in which KMC is operational,[f] by level of facility	No. of health facilities in which KMC is operational, by level of facility	Total no. of health facilities with maternity services	Direct observation	Facility surveys, self-assessments
Facility neonatal mortality rate disaggregated by birthweight: > 4000 g, 2500–3999 g, 2000–2499 g, 1500–1999 g, < 1500 g	No. of neonatal deaths by category of birthweight: > 4000 g, 2500–3999 g, 2000–2499 g, 1500–1999 g, < 1500 g	Total no. of live births in the health facility segregated by birthweight	Hospital statistics	Charts, internal monitoring system
Proportion of health facilities offering maternity services certified by the Baby-friendly Hospital Initiative and recertification not older than 2 years	No. of health facilities offering maternity services certified by the Baby-friendly Hospital Initiative and recertification not older than 2 years	Total no. of health facilities with maternity services	Direct observation	Facility surveys, self-assessments
Children				
Proportion of children who are correctly prescribed an antibiotic for pneumonia	No. of children with valid classification who are correctly prescribed an antibiotic for pneumonia (including doses, number of times per day and number of days)	Total no. of children with diagnosed pneumonia	Patient records, registers and direct observation	Presently collected in health facility surveys, hospital quality assessment tool
Proportion of children requiring referral who receive correct pre-referral treatment and referral	No. of children requiring referral who receive correct pre-referral treatment and referral	Total no. of children with severe disease requiring referral	Patient records, registers, referral cards and direct observation	Presently collected through health facility surveys, hospital quality assessment tool
Proportion of children with severe acute malnutrition who are correctly prescribed therapeutic feeding	No. of children with severe acute malnutrition who are correctly prescribed therapeutic feeding	Total no. of children with severe acute malnutrition	Patient records, registers, referral cards and direct observation	Direct observation[g]
Death rate of hospitalized children under 5 years	Total no. of deaths of hospitalized children under 5 years of age in a given period	Total no. of hospitalized children under 5 years for the same period	Hospital records and registers, outcome forms and death case reviews	WHO hospital quality assessment tool, SARA

Core indicator	Numerator	Denominator	Data source	Methods
General				
Proportion of health facilities that had stock-outs of essential lifesaving medicines for mothers, newborns and children in a specified period	No. of health facilities that had stock-outs of essential lifesaving medicines for mothers (oxytocin, magnesium sulfate, dexamethasone, oral amoxicillin, injectable gentamicin (context-specific malaria rapid diagnostic tests, antimalarial and antiretroviral agents)), newborns and children (vaccines, oral rehydration salt, zinc, oral amoxicillin, injectable gentamicin (context-specific malaria rapid diagnostic tests, antimalarial and antiretroviral agents in a specified period))	Total no. of health facilities	Out-of-stock cards and direct observation	Routinely collected and through health facility surveys, SARA and essential drugs survey
Proportion of maternal, perinatal and child deaths occurring in a facility that were reviewed	No. of maternal, perinatal and child deaths occurring in a facility that were reviewed[b]	Total no. of maternal, perinatal and child deaths in facilities	Hospital records, audit reports	Surveys
Proportion of health facilities with soap and running water or alcohol-based rub available in labour, childbirth, neonatal and paediatric wards	No. of health facilities with soap and running water or alcohol-based rub available in labour, childbirth, neonatal and paediatric wards	Total no. of health facilities	Direct observation	SARA, health facility surveys, self-assessment
Proportion of health facilities with safe, uninterrupted oxygen supply in childbirth, neonatal and paediatric wards	No. of health facilities with safe, uninterrupted oxygen supply in childbirth, neonatal and paediatric wards	Total no. of health facilities	Direct observation	SARA, health facility surveys, self-assessment

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Statement regarding conflict of interest

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